

The Health of Homeless People: a Housing Issue

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Declaration

I, David Robinson, hereby declare that the work contained herein is my own and has not previously been presented for examination.

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Abstract

Attempts to explain and manage the poor health profile of homeless people have focused on the problems homeless people encounter in accessing and utilising health care. I argue, however, that there are at least two other factors that could impact directly on the health profile of homeless people. First, it is widely acknowledged that living conditions affect health. It therefore follows that the extreme environments in which many homeless people live will contribute to their poor health profile. Secondly, evidence is emerging not only that people with health problems have difficulty in accessing permanent accommodation but also that sick people are disproportionately vulnerable to becoming homeless in the first place. This is despite the theoretical safety-net in the welfare arm of the housing service. It therefore seems plausible to suggest that health selectivity into and out of the housing system is also contributing to the poor health profile of homeless people. In this empirical study, I explore the relationship between housing provision, living space and servicing in order to better explain the health profile of single homeless people. I weigh up the influence of poor services, harsh environments and health selectivity drawing on the evidence provided by a series of qualitative, semi-structured interviews with 40 single homeless people living in Edinburgh.

To date, studies of the health of homeless people have been cross-sectional, providing a snapshot in time of factors associated with health and disease but remaining silent on how these links develop through time. In my study the interviews with homeless people were designed to allow a longitudinal analysis of the sequencing, combination and timing of events in health and accommodation histories. Assessment of these histories revealed two key findings. First, the majority of respondents had health problems before becoming homeless. They became and remain homeless because they have not been able to attain or sustain a place in the housing system. Second, the majority of respondents have experienced a deterioration in health that appears to be linked to the physical and servicing environments they have been exposed to since becoming homeless.

This study shows that people with health problems are vulnerable to homelessness, and that the health profile of homeless people is as much a reflection of housing inequalities as of inefficiencies in the health service. I argue that by tackling these inequalities, housing policy could go some way to meeting the health as well as accommodation needs of homeless people and so be harnessed to the aims of health and social policy. However, in conclusion, I question whether this theoretical goal is achievable in practice given the recent restructuring of the housing system and the associated separation of housing from other areas of health and social policy.

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List of Abbreviations.

<u>Abbreviation</u>	<u>Definition</u>
A and E	Accident and emergency department.
DoE	Department of the Environment.
DoH	Department of Health.
DSS	Department of Social Security.
GP	General Practitioner.
NHS	National Health Service.

Introduction

Homelessness is on the increase in many countries. It's causes are contested but it's consequences are all apparent. One area of growing concern is the health of homeless people. Accumulating evidence suggests that the homeless population are experiencing a high incidence of a range of mental and physical health problems compared to the housed population. This thesis focuses on homelessness and health in Britain, a country with a strongly developed welfare tradition including a National Health Service and a housing system geared to need rather than ability to pay. In particular, this thesis focuses on a key relationship; that between housing policy and the health of homeless people. My concern is with the extent to which the health profile of homeless people is a product of housing policy and provision, and with how housing policy might be orientated better to meet the health needs of homeless people.

I begin in Chapter One by identifying and outlining two factors that combine to produce the health profile of homeless people: the adverse effects of poor living and servicing environments, and the prospect of health selectivity into and out of the housing system. Chapter Two details the key research questions and provides an account of the methods and techniques adopted and adapted to explore them. I describe and justify a qualitative approach, introduce the semi-structured interview schedule I implemented, and outline the analysis of transcripts from discussions with a sample of 40 homeless people.

Chapters Three through to Seven are the empirical core of the thesis in which I weigh up the influence of poor services, harsh environments and health selectivity on the health profile of homeless people by analysing the health and accommodation histories of 40 interviewees. *A review of relevant literature is integrated into this empirical core*, rather than presented separately, to allow the best representation of the findings and to facilitate discussion of their significance. The ordering of Chapters Three to Seven is important because it reflects the path of reasoning down which I have travelled in coming to the view that the health of homeless people is a housing issue.

In Chapter Three I consider the health of homeless people. I discuss the findings of previous analyses and present the health profile of the 40 homeless people interviewed in this study. I then go on to discuss respondents' health histories. These unique data shed light on the controversial issue of health selectivity into and out of the housing system, as well as illuminating the impact of homeless on health.

In Chapter Four I explore the suggestion that homelessness is hazardous to health. Policy makers have frequently responded to the poor health profile of homeless people with ad hoc attempts to improve health care for homeless people. First, therefore, I use interview material to explore the problems homeless people encounter accessing and utilising health care. This raises questions concerning the health gains of improvements in health care for homeless people. Inadequate health care is not a major cause of ill health; better access is important for many reasons but removing the sources of illness is not one of them. Second, therefore, I explore the relationship between the changing health of respondents since becoming homeless and the environments in which they have lived. It is difficult to specify the biomedical processes that account for the impact of environment on health. Various living conditions have, however, been consistently related to a range of physical and mental health problems. By relating existing evidence to the conditions respondents have lived in since becoming homeless, I explore the possibility that some of the health problems homeless people experience stem from the substandard environmental and social conditions in which they live.

In Chapters Five and Six I explore the possibility that the health profile of homeless people is, in part, a product of people with health problems becoming and remaining homeless - health selectivity, against the interests of sick people, into and out of the housing system. Many respondents had health problems before they became homeless. It is commonly assumed that if housing provision is health selective it favours people with health problems. Chapter Five explores why, on leaving their last home, respondents failed to secure alternative permanent accommodation and became homeless. The reasons why respondents left home and their failure to secure permanent accommodation are evaluated and new evidence concerning their subsequent homeless accommodation careers is discussed.

In Chapter Six I explore respondents' attempts to escape homelessness. I focus on their attempts to access private rented, housing association and council housing and consider why

the rules, practices and procedures that govern selection and allocation in each of these sectors have not been health selective in their favour.

Chapter Seven brings together the findings documented earlier and draws out the evidence required to suggest how policy makers might best respond to the health profile of homeless people. In making these suggestions I consider the merits of, and prospects for, the welfare ideal that has played such a key role in the development of British housing policy and I provide a critique of the representation of homeless people in British society. In conclusion, I argue that policy is unlikely to respond to the health profile of homeless people as long as the neo-liberal welfare ideal dominates political debate and homeless people are represented as deviant and undeserving. Finally, I set out an agenda for future research in order to build on the discoveries of my own work.

HOUSING, HOMELESSNESS AND THE HEALTH OF HOMELESS PEOPLE.

Over the last 15 years there has been a dramatic rise in homelessness in Britain. In 1979 56,750 households were accepted as homeless by local authorities in England, Wales and Scotland. By 1990 the number had risen to 170,000 (GSS, 1992) and has remained consistently above 140,000 ever since (DoE, 1995; GSS, 1995). Moreover, official statistics only account for households recognised as homeless under the provisions of the homelessness legislation (Housing Act 1985 and the Housing Act Scotland 1987) and therefore exclude most single people and childless couples. In 1994 only 59.7% of people who applied to a local authority as homeless were accepted (CIPFA, 1995) and unofficial estimates put the number of single homeless people at around two million (CHAR, 1995).

The popular and all-too-often the dominant political view is that homeless people are individually responsible for their predicament. This is particularly true of single homeless people who are viewed as deviant and dysfunctional welfare scroungers who are homeless out of choice. Held personally responsible for becoming and remaining homeless, homeless people are constructed as undeserving of help. However, an accumulating body of evidence paints a rather different picture. Notwithstanding the political rhetoric, most research based explanations for the dramatic rise in the number of homeless people have focused on the changing nature of housing provision rather than on individual culpability. The continued decline of the private renting sector, the growth of home ownership and the decline of council housing have changed the pattern of access to housing (Murie, 1988). Together with increasing economic and social inequality, these factors have resulted in an increase in individual vulnerability to homelessness and put a growing population at risk. Homelessness is not an indicator of illness or personal inadequacy but a reflection of major inequalities in

access to housing (Connelly et al., 1991). We can appreciate why this is the case by examining the recent history of housing policy in Britain.

During the last 16 years housing policy has concentrated on the creation of a 'property owning democracy'. By encouraging new build programs, transferring rented housing into home ownership and subsidising home owners through tax breaks the government has ensured that home ownership has become the dominant housing sector. In 1979 53.3% of dwellings were in owner occupation and by 1990 the figure had risen to 67.6% (DoE, 1991). However, access to owner occupation is dependent on a household's ability to secure a sufficiently large and stable income to pay a deposit or repay a mortgage. Rising house prices, the long term decline of manufacturing industry, the growth of low paid, insecure service sector jobs and rising unemployment have meant that increasing numbers of people are unable to satisfy these affordability criteria. As a result, would be buyers have been priced out of the market and recent buyers have lost their homes through mortgage default, 76,000 owner occupiers experiencing repossession in 1991 alone (Bramley, 1994).

The private rented sector once provided a stepping stone from the parental home to owner occupation. However, the sector has declined steadily during the twentieth century and now accounts for less than 10% of the total housing stock. In an attempt to revive the sector the Housing Act 1988 deregulated future lettings. However, the main result has been dramatic rent increases and a growth in short term tenancies (Kemp, 1988). The majority of remaining supply is, consequently, expensive and insecure (Murie, 1988). From the 1950s, the decline of private renting was offset by a growing public rented sector. During the last 16 years, however, there has been a dramatic decline in the provision of public rented housing and local authorities and housing associations have faced increasing difficulties providing adequate housing for record numbers of applicants. The pattern of decline is as follows.

Council housing has been available on a national scale since the Addison Act of 1919 introduced government subsidies to local authorities for dwelling construction. Post 1945 there was a dramatic increase in council housing provision and the sector grew to dominate the housing system. By the 1970s, however, it was widely accepted that there was a crisis of council housing. Housing managers were complaining of problems managing a stock in the face of financial and operational constraints and council tenants were understood to be

unhappy with the condition of their housing and the service they were receiving from local authority housing departments. For supporters of council housing this crisis was a product of 'lost ideals and penny-pinching inadequacy' (C.D.P., 1975). However, for the post 1979 Conservative government the crisis represented not the failure *of* council housing but a failure *in* council housing (Cole and Furbey, 1994) - an inevitable product of the inability of local authority landlords to be efficient and responsive to consumers demands. This construction of the crisis of council housing as a product of the failings of local authorities as landlords has served two important purposes for the government. First, attention has been diverted away from pressures on the council housing service that have their origins in central government policy - financial restrictions, declining new build programs and poor long term maintenance - allowing central government to evade any responsibility for the crisis. Secondly, by blaming local authorities the government has legitimised the pursuit of and limited opposition against a tenurial revolution in housing provision away from subsidised public renting and toward subsidised owner occupation.

Driven by the desire to reverse the social democratic values of collectivism and interventionism that had defined housing policy since 1945 in favour of the rights of private property, the Conservative government set about dismantling the council housing service (Clapham et al. 1990; Malpass, 1993). The Housing Act 1980 introduced legislation giving local authority tenants the right to buy their properties at a discount, and during the first two terms of the Thatcher Government over one million council properties were sold (Cole and Furbey, 1994). The local authority new build program has been halted, dwelling completions falling from 85,049 in 1979 to 528 in 1994 (Dwelly and Blake, 1995), and whole council estates have been transferred to private landlords. In 1979 32% (6.7 million) of all dwellings in Britain were local authority tenancies, by 1989 the number had fallen to 23% (5.4 million) (DOE, 1990). The decline in council housing has not been matched by a corresponding increase in provision by housing associations, the politically favoured providers of social housing. In 1979 1.9% (0.4 million) of all dwellings were housing association tenancies, by 1989 this figure had only increased to 2.6% (0.6 million) (DOE, 1990). In summary, home ownership has been actively encouraged and subsidised renting has been systematically dismantled at a time when increasing numbers of households are facing economic insecurity. The result has been a rising tide of homelessness.

The recent dramatic rise in the number of homeless people has fuelled concerns among health care providers and policy-makers about the health of homeless people raised by accumulated evidence of a high incidence of a range of mental and physical health problems among the homeless population. The policy response has tended to portray the health problems of homeless people as caused and exacerbated by the difficulties people of no fixed address encounter accessing and utilising health care. Focusing attention on gaps in health care provision has secured important improvements in the provision of primary care for homeless people. However, this 'medicalisation' of the health of homeless people has shifted attention away from other policy areas that should be addressing their poor health profile. In particular, it has been argued that attention has been diverted away from the role of housing policy and provision at a time when the shift in emphasis from subsidised public renting to subsidised owner occupation has been at the leading edge of the restructuring of the welfare state along neo-liberal lines (Shanks and Smith, 1992).

The changing patterns of access to housing and the recent dramatic rise in homelessness raise a number of questions about the significance of housing issues to the health profile of homeless people. It has long been accepted that there is some relationship between housing and health. Housing provision was central to Britain's earliest public health campaigns and improvements in housing conditions were seen as vital to improving the health of the population. Accumulated evidence confirms that housing characteristics such as location, design and condition are correlates of mental and physical health problems. Smith (1990) argues that these associations can be interpreted in a number of ways. First, it seems plausible to suggest that certain housing environments have a health effect. If poor housing does cause poor health, it seems reasonable to suggest that homeless people will experience an above average incidence of health problems. Secondly, it is possible that the relationship between housing and health reflects not only the effects of housing on health, but also the selective availability of housing according to health status. If, in the restructured housing system, secure accommodation is less available to people with health problems than to people who are healthy this would also help account for the poor health profile of homeless people. The aim of my study is to explore the range of interpretations of the association between homelessness and poor health. To what extent is the health profile of homeless people a product of homeless living and servicing environments, and to what extent is it a consequence of the restructured

housing system that means people with health problems are unable to avoid and escape homelessness?

In the remainder of this chapter I will introduce the association between homelessness and health and outline plausible links between housing policy and provision and the health of homeless people.

1.1 Homelessness and Health.

In recent years there has been growing concern about the health of homeless people. Although problems of sampling, controlling and ensuring consistency make comparisons between different studies difficult (Shanks, 1981), there is little doubt of a strong relationship between homelessness and poor health. Small scale local studies and national surveys have reported that the physical and mental health of homeless people is considerably worse than that of the general public, although there is little understanding of why. Commonly reported physical health problems include infectious disease such as tuberculosis, chronic chest problems, dermatological problems, musco-skeletal problems, genitourinary problems, fits or loss of consciousness and haematological problems. Commonly reported mental health problems include functional psychoses, acute distress, personality dysfunction, schizophrenia and depressive illness.

The health profile of homeless people has typically been portrayed as caused or exacerbated by the limited availability of health care to people without a fixed address (for example, Lowry, 1989; 1990) and solutions have been couched in health care terms (Shanks and Smith, 1992). The 'medicalisation' of the health of homeless people is, to an extent, valid. Evidence suggests that the lack of a fixed address is a major constraint in accessing health care (Stearn, 1987). Problems accessing a general practitioner (GP) are the main reason why homeless people have difficulties accessing health care (Fisher and Collins, 1993). GPs are the gatekeepers of the NHS, controlling patients' access to their own time and expertise and to the rest of the NHS (Foster, 1983). Some GPs are unwilling to accept homeless people onto their waiting lists or do so only on a temporary basis. Consequently, some homeless people receive inferior and inadequate health care. Although the under-use of health care by homeless people is primarily a problem of service delivery, it has also been suggested that there is a reluctance

among some homeless people to utilise available care (Fisher and Collins, 1993). It is therefore important to improve the provision and uptake of health care for homeless people.

Debate regarding a suitable policy response to the problems homeless people encounter in accessing and utilising health care has centred on whether it is better to try and adapt the health service to meet the needs of all or to accept that the health service cannot be changed and treat homeless people separate from mainstream services (Baylis, 1993). No clear cut policy has emerged from this debate and the improvements in the provision and uptake of health care that have been secured are the result of ad hoc public and charitable provision on a local basis. For example, some surgeries have run GP registration campaigns with the aim of integrating the needs of homeless people into the NHS, some towns and cities have health care teams that visit hostels, day centres and locations where people sleep rough and provide care, support and referral to mainstream services, and walk-in clinics providing health care exclusively for homeless people have been opened in a number of locations. These attempts to improve the provision of health care for homeless people are a logical response to the poor health profile of homeless people, especially given evidence that the lack of a fixed address is a major constraint when accessing health care. However, it is difficult to assess what impact improvements in the provision and uptake of health care will have on the poor health profile of homeless people because we do not know if, how and to what extent inadequate health care contributes to the poor health profile of homeless people.

Studies of the health of homeless people have described the health profile of homeless people but little is known about the causes of this poor health profile. In response, this study will explore plausible explanations for the poor health profile of homeless people and critically evaluate the options available to policy-makers for tackling the health and homelessness problem. This will involve challenging the 'medicalisation' of the health of homeless people and exploring the potential of other policy areas to contribute to the management of the health profile of homeless people.

1.2 Housing Policy and Provision and the Health of Homeless People.

There are at least two factors other than the provision of health care that could impact directly

on the health profile of homeless people and both are a direct consequence of housing policy and provision.

1.2.1 Living conditions and health.

In Britain there is a long tradition of using housing provision as a public health intervention. During the nineteenth century the biomedical processes that link housing conditions and poor health were not understood but it was widely accepted that housing conditions impacted directly on health, and improvements in housing conditions were central to Britain's earliest public health campaigns. However, research remained unable to explain why poor housing was consistently associated with poor health and it became apparent that the housing problem was more than a public health issue. Health issues did not become the centre-piece of twentieth century housing policy. During the inter-wars years housing policy and provision did continue to take public health issues into account but it was increasingly assumed that the slum clearance programme would provide decent housing for all and eradicate the residential determinants of ill health (Smith, 1989). Post 1945 the slum clearance programme gained momentum and health concerns were pushed to the periphery of the housing agenda where they have remained ever since (Smith, 1989). However, slum clearance did not put an end to the impact of housing environments on health and evidence of a continuing link between housing conditions and poor health has accumulated.

It is difficult to specify the relationship between particular facets of housing environments and health problems. Poor housing environments are often associated with other hardships that can foster health threatening lifestyles, for example, unemployment and poverty. However, as we shall see in Chapter Four, dwelling construction and design, living density, cold and damp have all been implicated in the incidence of disease, although their relative efficacy as causal mechanisms remains to be established. Attention has also been paid to the role that housing circumstances can play in the progression of mental illness. Location, design, physical conditions, living density and security have all been implicated as having some bearing on mental health. The significance of these findings to understanding the health profile of homeless people is that being homeless often involves living in inadequate and hazardous physical conditions where facilities are unsafe, dirty or absent altogether. Living environments can lack privacy, restrict freedom and be cramped and over-crowded. If housing environments

impact on health, it seems obvious that the extreme environments in which many homeless people live will also impact on health.

If homelessness does impact on health, it is important that policy-makers rediscover the role housing can play as a health intervention. Decent temporary accommodation could limit the impact of homelessness on health and the provision of decent and affordable housing could limit the number of people exposed to the hazards of homelessness. However, rediscovering the role housing can play as a health intervention will involve acknowledging that the exposure of growing numbers of people to the unhealthy environments of homelessness is primarily a product of the decline in affordable housing (Shanks and Smith, 1992).

1.2.2 Health selection and housing provision.

Not only is homelessness potentially hazardous to health, but evidence is emerging that people with health problems are falling out of the housing system and into homelessness. Smith (1990) defines health selectivity in housing as the 'deliberately or inadvertently (health) selective operation of the bureaucratic rules and procedures invoked to allocate housing or to dispense housing finance'. Adopting Smith's definition, there seems little doubt that housing provision is health selective. People experiencing intermittent or permanent health problems are likely to face problems securing and maintaining a position in the housing market because they are unable to secure a sufficiently large and stable income to repay a mortgage or pay a deposit. Consequently, they are excluded from the housing market and forced to rely on public rented housing. Conventional wisdom assumes that the council housing service - the welfare arm of the housing system - offsets the inequalities of the housing market and is selective in favour of people with poor health. Therefore, people disadvantaged by poor health should be assured of a place in the housing system. However, the demise of council housing raises an important question: are the social gains of council housing being defended in the restructured housing system - do disadvantaged people have access to housing and freedom from homelessness?

There is no national system for allocating council housing and each local authority is free to determine its own allocation policy (Foster, 1983). However, local authorities are required by law to recognise certain needs. Health has long been influential in the allocation of council

housing. Throughout the 1950s and 1960s, as the council housing stock grew, people disadvantaged by ill health had the opportunity to rent at reduced rates. In 1969 the Cullingworth Committee included medical need in a list of 'special' social needs that local authorities should target housing toward and the importance of medical need was confirmed in the Chronically Sick and Disabled Persons Act 1970 (Smith, 1990). Throughout the 1970s, in recognition of the fact that intermittent or permanent ill health could limit income and, therefore, participation in the housing market, a wide range of health problems gave applicants some degree of priority access to council housing. The only other statutory basis for medical priority is the provision for 'vulnerable' people under the homeless legislation. Britain is unusual in having specific legislation to prevent homelessness among certain households (Anderson, 1993). The legislation, originally contained in the Housing (Homeless Persons) Act 1977 and now contained in Part III of the Housing Act 1985 and the Housing (Scotland) Act 1987, represents an important advance toward securing the right to housing at a time when the rights of private property are paramount (Clapham et al., 1990). Local authorities have a statutory duty to provide permanent housing if an applicant is in 'priority need', is not 'intentionally homeless' and has a 'local connection'. People are in 'priority need' if they have dependent children, are pregnant, are homeless due to an emergency such as fire or flood or are 'vulnerable' 'as a result of old age, mental illness or handicap or physical disability or other special reason', which case law has established can include illness (Watchman and Robson, 1990).

The homeless legislation and the incorporation of medical need into council housing allocation mean that, in theory, no matter how much the boundaries of the welfare state contract, homeless people with health and mobility problems should have high priority among people applying for council housing (Shanks and Smith, 1992). However, 60 years of fitful expansion of council housing provision have been followed by 15 years of steady disintegration (Cole and Furbey, 1994). Faced with a decline in the size and quality of stock and rising demand, local authorities are forced to exercise discretion when interpreting their statutory duties to applicants in order to limit demand and ration supply. Consequently, need, as recognised by the homelessness legislation and in the principal of medical priority, is consumed into a bureaucratic system for limiting demand and managing supply that reflects the size and quality of housing stock as determined by central government policy. As the council housing stock has declined so increasing numbers of people have been turned away from local

authority housing departments (Drake, 1989). Evidence also suggests that demand for access to public housing on the grounds of medical priority is high and increasing, and that a relatively large proportion of people who claim medical priority are failing to be housed (Smith, 1990).

In summary, growing concern among policy-makers and interest among researchers in the health of homeless people has focused on the provision of health care for homeless people. Evidence suggests, however, that homeless living conditions might be hazardous to health and that people with health problems are often unable to avoid and escape homelessness in the restructured housing system. Therefore, it is important that attention is paid to the relative contribution of health selection, unhealthy environments and inadequate health care to the health profile of homeless people.

1.3 Aims of the Study.

The state has long recognised that housing is a key determinant of opportunity and the history of post-1945 housing policy is one of state intervention to achieve social goals. However, the last 16 years have seen a dramatic shift in housing policy away from the social democratic values associated with the interventionist role of the state, and toward the neo-liberal ideal of 'rolling back the state' and faith in market provision. This shift in emphasis has given fresh impetus to long running debate about the social aspects of housing and whether housing policy should be considered a part of social policy. This study is an attempt to inform this debate by exploring the links between housing provision, homelessness and health.

Cross-sectional studies have speculated as to the determinants of the health profile of homeless people. In this study I will explore these speculations using a longitudinal approach. In particular, two relationships will be explored - that between homelessness and poor health, and that between health and selective entry to and exit from the housing system. The aim is to assess the contribution of a 'health selective' housing system to the health profile of homeless people and to explore the effectiveness of housing policy as a health intervention appropriate to the needs of homeless people. The key research questions are: to what extent do homeless people experience a deterioration in health because of their new physical and servicing environment, and to what extent do people with health problems become homeless because

they cannot attain or sustain a place in the restructured housing system? Only when these questions have been addressed will it be possible to move on and assess the health and welfare needs of homeless people with health problems and to establish the extent to which these needs can be met by housing interventions.

METHODOLOGY AND METHOD.

There are no strict rules governing data collection and analysis in social research. Research design involves creating a method that gathers information appropriate to the situation. Any given design is necessarily an interplay of resources, practicalities, methodological choices, creativity and personal judgement of the people involved (Patton, 1987). In this chapter I will review the decisions that determined the data collection and the analysis strategies adopted in this study.

Key research questions set a study's frame of reference and focus the collection of data on some role, relationship, routine or other social process. Therefore, I will start this review by discussing the key question which initially orientated the fieldwork. I will then move on to discuss the decisions I took when evaluating design alternatives and determining the interplay of data collection and analysis methods best suited to the project's needs. Throughout the chapter I will refer to problems I encountered in the field and during analysis.

2.1 Research Questions.

Any researcher comes to fieldwork with some orienting ideas (Miles and Huberman, 1984). These ideas are the starting point for the planning and delivery of a research project. I came to my fieldwork with one particular orienting idea - that the health of homeless people is a housing issue. This idea spawned a research question which was the starting point from which I explored the meaningful character of the relationship between homelessness and health; to what extent is the poor health of homeless people a product of homeless people becoming ill because of their physical and servicing environment, and people with health problems becoming homeless because they cannot attain or sustain a place in the restructured housing

system? This question was not a hypothesis I set out to test. The aim of the research was to develop understanding through systematic data collection and sensitivity to emergent issues. However, undeniable progress can be made by clarifying and developing research problems before fieldwork begins (Strauss, 1970). This question set the study's frame of reference and focused the collection of data on the relationship between health and homelessness.

Answering this research question meant collecting specific data on the lives, experiences and opinions of homeless people with health problems. In particular, the research design had to be capable of addressing three issues. First, the relationship in time between health and homelessness. If homeless people had health problems before they became homeless then it is logical to infer that the health profile of homeless people is, in part, a product of people with health problems becoming homeless. Alternatively, if homeless people have experienced a deterioration in health since becoming homeless it is reasonable to suggest that the poor health profile of homeless people is, in part, a product of the impact of homelessness on health. Secondly, if people had health problems before becoming homeless, it is important to investigate why they became and remain homeless when, in theory, people with health and housing needs have high priority among people eligible for social housing. Thirdly, if people had experienced a deterioration in health since becoming homeless, it was important to investigate how homelessness impacts on health.

2.2 A Qualitative Approach.

The methodological challenge set by the key research question was to develop a research design capable of collecting longitudinal data on the health and accommodation histories of homeless people with health problems. Typically, research into health and homelessness has been limited to cross-sectional analysis of the range and incidence of mental and physical health problems among samples of homeless people. These studies have described the health profile of homeless people and succeeded in drawing attention to the health and homelessness problem. However, an individual's health status is the product of the ongoing interplay of various factors overtime - socio-economic and physical environment, lifestyle, genetics/constitution and health care - and only through the longitudinal analysis of change over time can patterns of change be noted and the direction and magnitude of possible causal relationships examined. It was therefore important to develop a strategy capable of relating the

sequence, combination and timing of experiences and events in the lives of homeless people to their changing health status.

The first step in the development of the research design was to determine how to access relevant data. There is no existing record of the accommodation histories of homeless people and the only possible source of data on health histories was NHS patient records. Patient records are difficult to access and, because of under use of health care services by homeless people due to problems of access and utilisation, are unlikely to provide a comprehensive picture of homeless people's health histories. Therefore, homeless people themselves were the only source of relevant data, but how to collect longitudinal data on health and accommodation histories from homeless people?

Without understanding the complex relationship between housing, homelessness and health, it was not possible to restrict data collection to measuring the impact of predetermined factors on the health of homeless people. Rather than determining 'how many things there are', the challenge for the research design was to find out 'what exists' - to go beyond description and unearth and explore the complexities of the relationship between housing and health. The research design had to be capable of identifying and exploring issues and oriented toward identifying connections between social phenomena and the lives of homeless people. These research needs match the relative strengths of qualitative methods and the emphasis they place on the meaningful character of social phenomenon and the need to take this into account in describing, interpreting or explaining social action (Tesch, 1990).

There are a multitude of different qualitative research methods and techniques. The relevance of each procedure to a research project depends on the data being analysed and the particular purposes and preferences of the individual researcher (Dey, 1993). Therefore, I had to determine which data collection techniques were likely to be productive given practical and personal demands. In assessing different approaches I viewed qualitative methods as involving techniques that elicit descriptive and interpretative data on social phenomena and their meaning to people who experience them. In doing so I rejected the narrow association of qualitative data with approaches emphasising unstructured methods. My concern was to adopt a method of data collection that would elicit data of depth and detail about the lives of homeless people with health problems.

Considering a range of methods, it soon became apparent that interviewing was the most suitable research technique given the practical and methodological demands of the study. By 'interview' I am referring to a social encounter between two people in which one is interviewer and asks questions relevant to the focus of the research and one is respondent whose responses constitute the raw data to be analysed. The main reason why interviewing was the most suitable research technique was because of the need to collect longitudinal data from homeless people. There are three basic ways in which longitudinal data can be collected. Prospective designs collect data on the same case two or more times, repeated cross-sectional designs collect data on different but comparable cases two or more times and retrospective designs collect data at a single time on the same case for two or more periods. A repeated cross-sectional design was of no use because it would allow group but not individual experiences to be monitored and related to changes in health. A prospective design was of no use because it was a practical impossibility to select people with health problems in the knowledge that they would become homeless and follow them through the months or years they were homeless. Given time and resource constraints, the only way to collect health and accommodation histories was to employ a retrospective design and elicit data through recall methods in an interview setting.

An interview can take many different forms depending on the practical and theoretical demands of the research, each type of interview being designed to achieve a particular task. The challenge in this study was to develop an interview design that facilitated the collection of retrospective data on health and accommodation histories and allowed specific issues to be explored while being sensitive to emergent issues. The most common classification of interview design is in terms of their degree of standardisation - the degree to which the interviewer is allowed to vary the content and order of questions (Ackroyd and Hughes, 1983). At one extreme is the structured or standardised interview in which it is assumed that the interviewer already knows exactly what the interview is designed to uncover and has a set of questions that are relevant, unambiguous and will provide clear and relevant replies. In theory, the output is aggregated data that can be examined for patterns among the target population. Unaware of the exact issues the interview would cover and wanting to explore experience in depth and detail, a structured design did not match the demands of this study.

At the other extreme to structured interview designs are unstructured or non-standardised interviews in which it is assumed that the interviewer does not know in advance what questions to ask but appropriate questions will emerge during the interview. The unstructured interview is open-ended and facilitates the discovery of 'grounded theory' from data (Glaser and Strauss, 1967). The interviewee is free to talk within their own frame of reference, allowing the interviewer's perceptions to be challenged and the meanings and interpretations of events and relationships to the respondent to be understood (May, 1993). An unstructured approach would have satisfied many of the demands of this study, eliciting respondent's own unique perceptions and experiences in depth and detail, and would seem to be a suitable medium for collecting oral histories. However, this study was specifically concerned with collecting housing and health histories and it was therefore important that I, as interviewer, could set the interviews frame of reference while remaining sensitive to emergent issues. Therefore, the needs of the study best suited a semi-structured approach. The assumption in semi-structured interview designs is that the interviewer has a specific issue that the interview will explore but does not claim to know all the right, relevant or unambiguous questions. A set of questions, some open ended and some pre-coded, provide a loose framework from which the interview can deviate but will return.

Therefore, individual homeless people with health problems were the only source of information and semi-structured interviewing was the most suitable method of collecting data. However, before the interview schedule could be formalised there were a number of theoretical and practical decisions to be taken regarding the sample population.

2.3 Defining the Sample.

Sampling is a set of rules which place the observer in a situation to record or elicit a set of behaviours or experiences that are presumed to have some degree of relevance for a specific question or proposition (Denzin, 1978). The logic of sampling in qualitative research is different to the logic of sampling in quantitative research. The aim of sampling in quantitative research is the selection of a sample that is typical or 'representative' of the parent population so that the incidence of characteristics in the sample reflect the incidence of characteristics in the parent population allowing statistical inferences to be made about the general population from the sample (Clyde Mitchell, 1983). The logic of sampling in qualitative methods is to be

purposeful in selecting information rich cases which allow in-depth study of issues of importance to the research (Patton, 1987). Statistical inference is not invoked and representativeness is not an issue. The aim is the collection of detailed data that provides an intimate knowledge of the connections between the circumstances surrounding a case and allows the inferential process to consider the theoretical linkages among features (Clyde Mitchell, 1983). In this study, the starting point in selecting an information rich sample was specifying a workable definition of homelessness.

Defining homelessness is important because the definition adopted has major implications for the quantification and analysis of causes of the problem (Watson and Austerberry, 1986). Definitions of homelessness have typically been divided into the 'official' and 'common-sense' (Bramley, 1988). Official definitions are legally founded and concerned with categories of people who upon presenting their problems to a local authority housing department have defined rights, as contained in the Housing Act 1985 and the Housing (Scotland) Act 1987. Common-sense definitions are based on the belief that a person is homeless if they lack the right of access to their own secure and minimally adequate housing space (Bramley, 1988). Both common-sense and official definitions can be challenged as inadequate because they fail to recognise that home is a place rich in emotions and feelings of well being and security and, therefore, reduce a cause of human misery to a technical and legal problem of housing supply (Sommerville, 1992). Experiential definitions argue that homelessness is an experience centred around people's own emotions and feelings related to the circumstances and situation in which they live. Certain circumstances and situations may be common to each person's experience of homelessness, for example, it is undeniable that a lack of adequate housing is central to the physical and emotional insecurity of homelessness for most people and that the right to decent housing would go a long way toward tackling homelessness in Britain. However, circumstances and situations are not defining characteristics of homelessness or homeless people. I would suggest that a person is homeless if they do not have the physical and emotional security of home that they want and need.

It is important to recognise experiential definitions of homelessness. Homelessness is more than no housing. However, the corollary of experiential definitions is that there is no one definition of homeless, every person having their own experience of home. Consequently, experiential definitions were of little practical use when defining an information rich sample

relevant to the concerns of this study. In order to focus attention on homeless people who have lost relatively secure permanent housing, I had to employ a working definition of homelessness. In doing so I followed Watson and Austerberry's (1986) notion of a home-to-homelessness continuum and the hierarchy of accommodation along this continuum from sleeping rough to outright ownership. Homelessness was equated with sleeping rough and living in temporary accommodation (short and long stay hostels, lodging houses, bed and breakfast 'hotels', short stay supported accommodation and sharing with friends and relatives) and home was equated with relatively secure rented or owner occupied housing (where the respondent or their partner was the lease/mortgage holder or was living with a parent or guardians out of choice). This working definition sub-divided the homeless population and focused attention on the lives of homeless people who have lost permanent housing and are now living in temporary accommodation or on the streets.

Having constructed a working definition of homelessness I next had to determine which people to talk to within the defined population. In doing so I employed a number of different sampling strategies. First, I employed the simple criterion that all respondents must have current health problems or have had problems at the time they became homeless. Interviewing homeless people without health problems would be of use if the aim of the study was to quantify the significance of different factors to the relationship between homelessness and health, as homeless people without health problems would provide a control group against which to compare the experiences of homeless people with health problems. However, the aim of this study is to identify explanations for the relationship between homelessness and health and the only way to gain an insight into this relationship was through the experiences of people with health problems. In practice it was not possible to identify people with health problems prior to interviewing so the schedule was designed to bring the interview to a close if upon questioning it became apparent that a respondent had no current or past health problems.

A second sampling strategy was to focus on single people. Single people, couples and families are all experiencing homelessness in Britain today. However, I considered it unrealistic to hope to capture the circumstances and experiences of all types of household in a small scale in-depth study working within strict time and labour constraints. Instead, I focused on single people as an extreme case. Since the mid-1980s there has been a substantial rise in the number of single homeless people. Single people do not have the same rights of assistance under the

homeless legislation as other households (such as homeless families with children), have low priority on waiting lists for social housing and face problems securing housing in other tenures (Anderson, 1994). Given the notable failure of housing policy to cater for single people, I saw single homeless people as the case from which most could be learnt. A third sampling strategy was to interview single homeless men and women of different ages and from different ethnic categories living in various circumstances because, although there is no agreement about what homelessness is, who is homeless and in what circumstances homeless people are living, it is undeniable that homelessness is affecting all sections of society.

I was successful in accessing accounts from single homeless men and women of different ages but was unable to access the accounts of people from minority ethnic groups. I tried but failed to access services targeted at specific ethnic groups and no people from racialised minorities volunteered to be interviewed during fieldwork in services for homeless people. It is not clear why I was refused access to services, but given evidence that homeless people from racialised minorities are disproportionately represented among the population of hidden homeless people who often have no contact with statutory or voluntary services (O'Mahony, 1988), it was not surprising that no people from minority ethnic groups volunteered to be interviewed during fieldwork.

The failure to interview people from different ethnic categories is an unfortunate flaw in the study. The growth of homelessness since the mid-1980s has undoubtedly affected people from minority ethnic groups. The influence of 'race' and racism on access to council housing has been well documented (Henderson and Karn, 1987; Smith, 1992; Ginsberg, 1993). Evidence also suggests that black people suffer a greater degree of homelessness than white people (SHIL, 1989) and that applications from racialised minorities under the homeless legislation and for medical re-housing are treated less favourably by some local authority housing departments (C.R.E., 1984a; 1984b; Bonnerjea and Lawton, 1987). Clearly, it is crucial that research attend to the specific experiences of homeless people from racialised minorities (this point is discussed in Chapter 7). The only conclusion that might be drawn from this study regarding the experiences of homeless people with health problems from racialised minorities is that if the homeless people interviewed are experiencing difficulties avoiding and escaping homelessness, homeless people who have also to contend with racism are bound to be experiencing difficulties.

The interviews were all conducted in Edinburgh, the capital city of Scotland. Edinburgh is located on the east coast of Scotland and has a population of 441,600 (OPCS, 1994). Edinburgh was chosen for a number of reasons. First, Edinburgh may be seen as a typical large British city. Its housing tenure profile matches the UK average - in 1991, 66% of dwellings were owner occupied, 9% were private rented, 4% were housing association and 20% were local authority rented (OPCS, 1994). Although no data exists on housing demand or need, anecdotal evidence and levels of service utilisation suggest that many people are homeless in Edinburgh. Second, I was living in Edinburgh during the course of the research and was able to gain personal knowledge of homelessness in the city which gave me a sensitivity to the context of the study and the lives of the people interviewed. I gained an insight into homelessness in Edinburgh by working in a day centre for homeless people on a voluntary basis. By spending time talking to people about their experiences and chatting to day centre staff I got to know about service provision for homeless people, including advice and health care services, long and short stay hostels, lodging houses and temporary supported accommodation projects. I also gained an insight into the rules and procedures of local housing associations and the local authority housing department by talking to people about their experiences of trying to secure permanent housing. This knowledge was vital to the success of fieldwork, allowing me to identify and access settings where I could talk to homeless people, use familiar language and jargon and offer advice to respondents about local services.

Having defined the sample, the next consideration was the sample size. A common assumption when determining sample size is the larger the better. This is true when drawing a 'representative' sample for the purpose of statistical inference. However, when exploring the relationship between phenomenon, the sample must reveal depth rather than width. Therefore, the main concern when determining the sample size was to define a sample that would permit, by virtue of not being too big, deep case-oriented analysis and would result, by virtue of not being too small, in a new and rich understanding of the experiences of homeless people with health problems (Sandelowski, 1995). I set an arbitrary figure of 40 interviews as a target in the hope that detailed analysis of a range of experiences would be possible and would be adequate to support this particular qualitative enterprise.

2.4 Gaining Access to Respondents.

Gaining access to the interview setting involved negotiating the presence of a range of homeless people who were aware of the focus of the research and willing to accept my activities as interviewer. The setting had to be a quiet space where the interview could be conducted in private and tape recorded. These demands forced me to access the interview setting through accommodation and support services used by homeless people in Edinburgh. A number of services for homeless people in Edinburgh were helpful in providing me with a private space in which to conduct interviews and allowing me access to their service users. By interviewing in different projects serving different people I was able to interview a range of homeless people living in different circumstances and situations.

Using personal knowledge of the service setting in Edinburgh, I determined which services to approach in order to build up a sample of single homeless men and women of different ages living in different circumstances. I approached seven hostels (two serving homeless women, four serving homeless men and one serving homeless young people), two day centres (one for homeless people and one for people with mental health problems), a support and advice service for young people, an advice service for homeless people, a cheap food service and two housing associations that provided temporary supported accommodation for young people. The initial approach involved a letter to senior members of staff introducing myself and the work I was undertaking and asking for a meeting to talk about the service's work with homeless people. I did not mention that I wanted to interview service users in this initial letter for fear of scaring off these gatekeepers and because I felt the request could be better articulated in a face to face meeting. Subsequently, meetings were set up with staff at three of the six hostels, one for women and one for men (three hostels either refused a meeting or never replied to follow-up letters and phone calls), the two day centres, the support and advice service for young people, the advice service for homeless people, the cheap food service and the two housing associations.

The aim of the meetings with senior staff at these services were twofold. First, I wanted to gain an insight into service provision for homeless people in Edinburgh so interviews would be sensitive to the context of respondents' lives. Secondly, I wanted to negotiate access to service users. Doing so involved gaining the confidence of service staff by showing that I was

knowledgeable in their field of work and would be sensitive to the welfare of their users. I took care in presenting the research as an organised, valid and worthwhile project that would provide results of use to policy-makers and service providers working with homeless people who have health problems. I also informed service providers how I would be collecting data and the nature of the questions I would be asking. An important outcome of these meeting was the finding that projects providing services for homeless people in Edinburgh and homeless people themselves were 'research weary' after being involved in a number of recent studies. Furthermore, recent studies had paid interviewees for their time and I was told by staff at a number of projects that I would experience serious problems raising any interest among their users unless I offered financial recompense. Consequently, I secured funds and offered £5 to each respondent. Paying respondents created no obvious problems and financial enticement was at all times tempered by informing potential interviewees exactly what the interview would entail.

After outlining my research and appealing for help I left the project staff to consider their decision. At a later date they were sent a copy of the interview schedule and asked to confirm if they were willing to participate in the study. At all times I ensured that control was in the hands of project staff, both out of respect for the help they were giving me and in the hope that if they felt in control they would be more willing to help out. These tactics had the desired effect. All the service providers with whom I had meetings agreed to allow me to interview people using their services. In one case, agreement was only given after I attended a user's forum and talked to service users about my research and what the interview would involve. The other projects gave me access after viewing a copy of the interview schedule. Subsequently, convenient dates and times for interviewing were arranged.

Exactly how the interview strategy then progressed was dependent upon the concerns of the service provider. Some services allowed me to stay in the project for a number of days, mixing with and talking to service users and interviewing anyone who was willing. Other services preferred to limit my presence to a particular day or days and inform users that I would be at the service and interviewing on those days. There were a number of dangers with this second strategy. First, staff might (unintentionally) misinform potential respondents about the interview process and thereby either scare off respondents or get people involved who were not prepared for what the interview process would involve. Secondly, staff might sample out

certain people as 'unsuitable'. Thirdly, I might only have been allowed access at a time when many users were not present. I limited these problems by making clear my needs. I requested that I was allowed access at a time when a range of users would be present. Information sheets and posters designed to advertise the interviews to service staff and users and reiterating my willingness to talk to anyone, my independence from any authorities and the complete anonymity that all respondents were assured were sent to all participating projects (see Appendix 3).

Advertising the interviews meant I lost control of the selection of respondents, it being unacceptable to advertise for willing participants and then refuse to interview people who volunteered, especially when they were expecting to receive £5. However, this was not a problem because each of the seven projects where interviews were carried out served a different user group (age, sex, situation) and the study was therefore guaranteed a sample of single homeless men and women of different ages living in different circumstances. Dates were set for interviewing at ten projects. Three of the ten withdrew from the study before interviewing commenced. A housing association had been unable to trace any people willing to be interviewed, a hostel was in the process of relocating and the cheap food service was temporarily closed due to staff illness. Therefore, interviews with 40 homeless men and women were conducted at seven service settings over a period of three months (Table 2.1).

Table 2.1 Number of interviews at each location.

<u>Location of interview</u>	<u>Number of people interviewed</u>
Support service for young people.	3
Advice centre for homeless people.	12
Supported accommodation for young homeless people	3
Day centre for homeless people.	5
Direct access hostel for homeless men	7
Day centre for people with mental health problems.	2
Direct access hostel for homeless women.	8
<u>Total</u>	<u>40</u>

Twenty-five (25) of the homeless people interviewed were men and 15 were women. Only two of the 40 had no current or recent health problems. The age of respondents varied from 17 to 68 years. The majority were aged less than 40 years, although the majority of women were aged less than 30 years (Table 2.2). The reason for the failure to access accounts from older women is not known. It could be that there are relatively few elderly women who are homeless, or it could be that the sampling technique focused on services not utilised by elderly homeless women.

Table 2.2 The age profile of the interview sample.

<u>Age Group</u>	<u>All respondents</u> <u>(n=40)</u>	<u>Women</u> <u>(n=15)</u>	<u>Men</u> <u>(n=25)</u>
16 and 17	2	2	-
18 to 30	18	10	8
30s to 40	6	1	5
40 to 50s	7	2	5
50s to 60	5	-	5
over 60	2	-	2

Respondents were living in various circumstances when interviewed (see Table 2.3). Not surprisingly, given that two of the interview settings were direct access hostels, the majority of respondents (23) were living in hostel accommodation. However, the current circumstances of the 40 respondents covered the range of temporary accommodation and roofless situations classified as homeless by the working definition of homelessness (see section 2.3).

The length of time that respondents had been homeless varied from a matter of days to over 10 years (Table 2.4). All 40 respondents were out of work and claiming social security benefits. Twenty-eight (28) were in receipt of income support or unemployment benefit. Twelve (12) were recognised by the state as unable to work because of health problems and were in receipt of invalidity or sickness benefit (as of April 1995 invalidity and sickness benefit were replaced by incapacity benefit).

Table 2.3 Respondents' accommodation at time of interview.

<u>Accommodation type</u>	<u>Number of respondents (n=40)</u>
Temporary supported accommodation for young homeless people	7
Sharing with friend/relative	2
Direct access hostel for men/women	23
Women's refuge	1
Lodging house	2
Temporary council flat	1
Squatting	1
Sleeping rough	3

Table 2.4 Length of time respondents have been homeless.

<u>Length of time homeless</u>	<u>Number of respondents (n=40)</u>
Less than 6 months	10
6 months and over/less than a year	6
1 year and over/less than 2 years	5
2 years and over/less than 5 years	3
5 years and over	16

Having determined to collect data through interviewing and gained access to a sample of 40 single homeless men and women with health problems of different ages and living in a range of circumstances, I implemented an interview schedule that had been designed to elicit respondents' health and homeless histories (these histories are summarised in Appendix 1).

2.5 The Interview Schedule.

A number of design considerations had to be incorporated into the interview schedule. In particular, the schedule had to establish respondents' personal characteristics (age, sex, marital status and employment status), accommodation histories (last home and the physical and social environments lived in since becoming homeless), health histories (current health, health when last at home and change in health since becoming homeless), attempts to avoid and escape homelessness (approaches to local authority, housing association and private rented landlords for permanent housing) and accommodation wants and needs. All the data had to be accessed in a single interview. Single interviews were favoured because of potential problems of re-contacting people of no fixed address and the time and labour that re-interviewing would involve.

An important consideration in designing the schedule was the need to facilitate recollection of accommodation and health histories. Recall is dependent on memory and memory can fade and be reconstituted with time. However, there are techniques that encourage recall and limit the collection of data distorted by time. First, memory tends to fade further away from an event (Moss, 1979). Consequently, I limited discussion to the previous five years and collected recall data either back to when the respondent was last at home (as defined in section 2.3) or for the last five years depending on which was the more recent. Limiting discussion to the last five years limited the collection of recall data distorted by time but allowed the study to appreciate the experiences and opinions of people who had been homeless on a long term basis. As a result of the five year cut off, health and accommodation histories were not traced back prior to homelessness for 10 of the 40 respondents. However, these 10 respondents were still interviewed in order to assess their health status and access their accounts of being homeless and attempts to escape homelessness.

Secondly, most people organise memories by the sequence of events rather than dates (Gant, 1987). Therefore, structuring an interview so it follows a sequence of events in the respondents' life can aid recall (Hindley, 1979). Consequently, I designed the schedule so that the recollection process started by taking respondents back in sequence through the different places they have lived since leaving their last home. The hope was that doing so would serve as a guide to me, as interviewer, to the situations, circumstances and time-span that the

interview would cover and would serve as a memory exercise for respondents. The challenge was to then flesh out this framework through further questioning. Thirdly, specific questions are much more likely to reveal past experiences than general questions (Gittins, 1979). However, specific questions are only likely to reveal experiences in depth and detail if the event in question is related to the respondents personal experience (Peters, 1989). Therefore, the interview schedule linked specific questions of relevance to the study to discussion of issues of importance to the respondent. Respondents were encouraged to talk about issues of importance to them at a time of significance to the study and then discussion would move on to probe events and experiences of direct relevance to the research. The hope was that respondents would find the interview stimulating and relevant to their personal experience and would be able to remember.

The wording and sequencing of questions was another important consideration when designing the schedule. An interview question is a stimulus that aims to generate a response from the person being interviewed and the collected data is a product of the questions asked (Patton, 1987). Different questions stimulate different responses and the same question can mean different things to different people. To limit misinterpretation and allow the significance of responses to be understood, questions were made as clear as possible. This involved using language relevant to the lives of homeless people in Edinburgh, asking questions one at a time and prefacing or contexting questions with a defining statement. The aim of contexting questions in this way is to limit the influence of unstated assumptions about the context of questions (Gorden, 1975). Contexting was used extensively when asking sensitive questions in order to introduce the subject and reiterate the respondent's right to refuse to answer. The hope was that contexting would limit alienation from the interview setting, limit misinterpretation and encourage respondents to talk about their own experiences in their own way. Other tactics I adopted when designing questions were to avoid emotive terms that could load questions with meaning and force rather than encourage recall, avoid asking questions that suggested an appropriate response and avoid incorporating popular assumptions about the lives of homeless people.

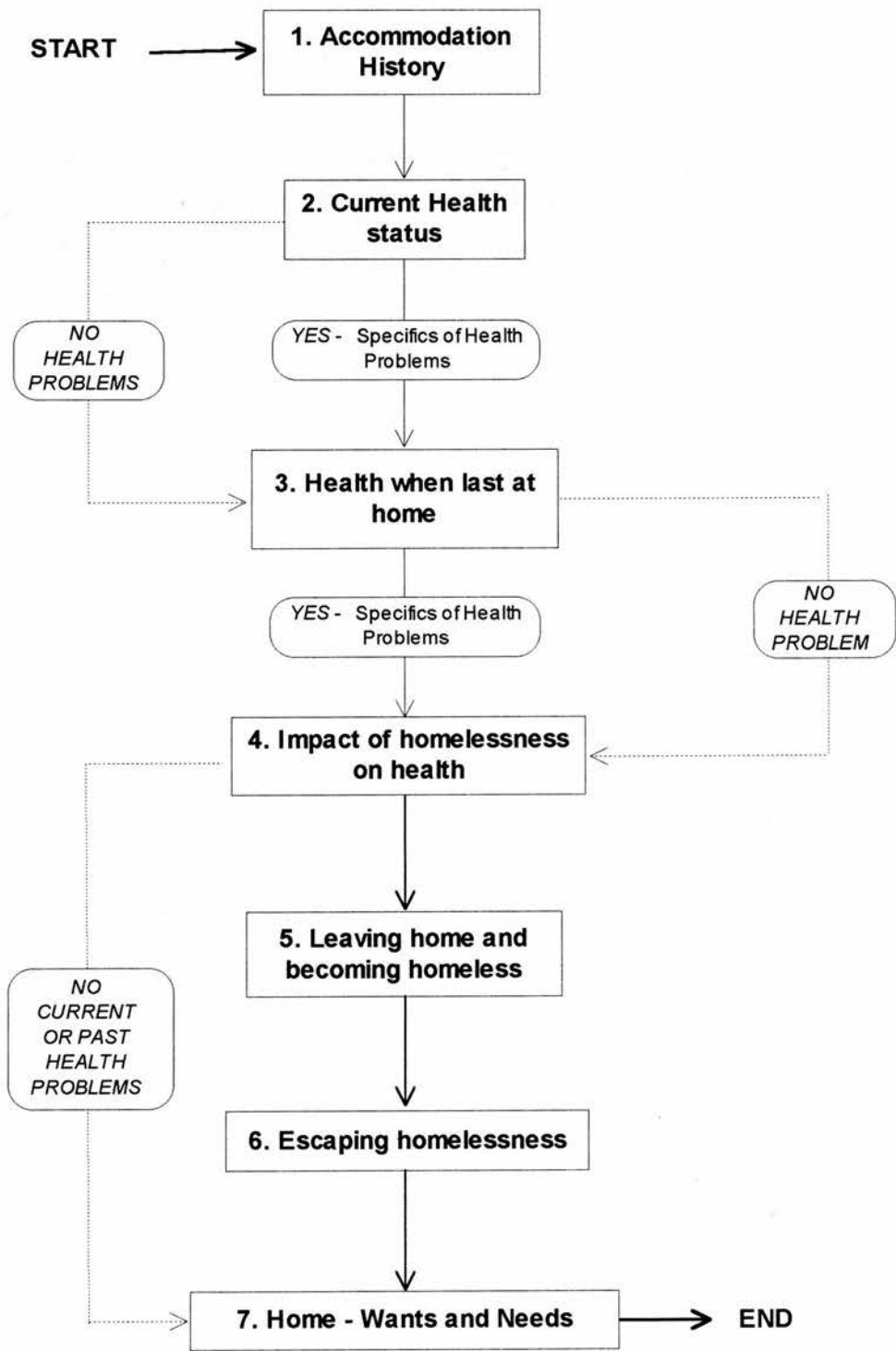
Care was taken with the wording of questions in order to ensure they were as clear as possible and to limit different understanding of what the question was asking. However, the meaning of questions was not always clear to respondents. More than once a respondent asked what I

meant by a particular question, which I then had to rephrase. Also, on some occasions respondents reinterpreted the meaning of a question and answered a different question. It was not clear if this was because respondents did not understand the question, misinterpreted the question or answered the question in a way that did not fit my own interpretation. Either way, I responded by rephrasing the question and asking it again later in the interview. As well as the wording of questions, careful consideration was given to the sequence in which questions were asked. Opening questions were designed to be non-controversial, clearly connected with the subject of study, open ended and concerned with issues respondents would find easy to talk about. The hope was that these 'easy' questions would encourage respondents to talk descriptively and show them that the study was interested in what they had to say. The same technique was used whenever discussion moved onto a new subject or time period and when a sensitive issue was addressed. General questions were followed up with probes that aimed to elicit greater detail. So as to aid the flow of the discussion and to appear less threatening, probes were often asked in a conversational style and adapted to the dynamics of each particular interview.

The schedule design was fine tuned through pilot interviewing. Pilot interviews were conducted with three homeless people with health problems. Each interview was transcribed and the data analysed. Consequently, small adjustments were made in the wording and sequencing of questions in order to improve the quality and relevance of collected data. The result was a schedule that in practice succeeded in fostering a relaxed interview environment and guided the interview through discussion of the respondent's health and accommodation history in a logical and consistent manner while guaranteeing sensitivity (see Appendix 2).

The schedule was divided into seven sections (see fig. 2.1). The second and third sections focused on respondents' current and past health status. There are different methods for studying health and illness and the focus of any study depends on the conceptualisation of health. The dominant paradigm is that held and put forward by the medical profession and focuses on organic or physiological disorder. The medical profession plays the key role in defining the organic dimension of health and the focus is on the signs or symptoms of disease, if in process, and impairment if static or persistent (Long, 1984). Studies of the health of homeless people are typically set within this medical paradigm and have focused on the organic health of homeless people. However, the medical paradigm neglects the functional and

Figure 2.1 The interview schedule.



social dimensions of health. The functional dimension of health is an individual's subjective state of psychological awareness of limitations in functioning, referred to as illness if in process and disability if static (Susser, 1973). The individual plays the key role in defining the functional dimension of health. The social dimension of health is the socially accepted or acknowledged limitations that an individual's health places on their role in society, referred to as sickness if in process and 'handicap' if persistent (Susser, 1973). Society and the medical profession play the key role in defining the social dimension of health.

In designing the interview schedule I attempted to acknowledge all three dimensions of health and develop a health related quality of life questionnaire. Questions about health and everyday life - problems getting around, walking, being worried, feeling down, being in pain and such like - were employed to uncover functional limitations. Questions about health and role in society - treatment by other people, by employers, benefit agencies, housing providers and impact on opportunities - were employed to uncover limitations in a respondent's role in society. Questions about health problems - signs and symptoms, advice, diagnosis and treatment from health workers - were employed to uncover recognised physiological and psychological disorders. Together, these questions were used to build up a picture of each respondent's current health status. Medical professionals might argue that lay persons are incompetent judges of health and disease and the reliance on perceptions of the general public raises questions of reliability and subjectivity. However, research has confirmed that self reported health measurements are relatively accurate indicators of morbidity (Hunt et al., 1986). What is more, individuals are the best judges of their own functional dimension of health and no one can have more experience of the impact of health on role in society than people labelled 'sick' or 'handicapped'.

Within each of the seven sections a number of key questions were asked, supported by a number of prompts. Beyond these questions discussion was free to wander. The interview was not intended to automatically proceed through all seven sections but was designed to proceed along a number of possible pathways depending on the individual circumstances of each respondent (see Fig 2.1). Consequently, information could be elicited on homeless peoples' health and accommodation histories, experiences and opinions in a one off, hour long interview that was recorded on audio tape for reasons of rigour and ease of analysis.

2.6 Interview Techniques.

An interview involves the development of a relationship between the researcher and the respondent. This relationship is critical to the quality of data obtained. Developing a productive relationship involves a combination of inter-personal skills and interviewing techniques. Building rapport involves developing a basic sense of trust between interviewer and respondent and is essential to the free flow of data (Spradley, 1979). I developed a number of techniques through pilot interviewing and drawing on previous interviewing experience in order to build rapport with respondents. At the start of the interview I introduced myself, what I was doing, the general aims of the study and how the interview would proceed. I also reiterated that there was no pressure to get involved or disclose information and that the respondent could withhold information or withdraw from the interview at any time. The aim of this introduction was to build trust, establish the legitimacy of the interview in the eyes of the respondent and to allow them to judge whether it was worthwhile getting involved. Doing so seemed to remove some of the tension that inevitably existed. The general atmosphere was also improved by friendly small talk that was often entered into before formally starting the interview. I continued to work on developing rapport during the interview by offering respondents something in return for their time and effort. This involved answering respondents' questions about my own experiences, talking about issues unrelated to the study but of concern to the respondent and providing advice about housing and health services.

As well being important in the development of a productive relationship, the techniques I used to build up rapport ensured that the principals of non-maleficence and beneficence were incorporated into the interview process. The introduction to the interview ensured that respondents were able to make an informed and voluntary decision to get involved. Giving something in return meant that respondents could get something out of the interview and reiterating the right to withhold information and withdraw from the interview all together helped put respondents interests first. However, ethical dilemmas can arise from establishing rapport. Respondents might become sufficiently relaxed to answer delicate personal questions which they might later regret. I cannot say whether respondents in this study regretted providing any information. However, respondents did tend to talk in greater depth about personal issues the longer the interview had gone on and it was difficult to balance concern

about people unwittingly providing information they would later regret against the principal of letting respondents talk at length.

A further problem in the interview setting was that no amount of rapport could hide the fact that the interviewer - respondent relationship was a power relationship. As interviewer, I was asking the questions and directing the discussion. A problem with this imbalance of power can be that respondents answer questions in ways that are considered 'socially appropriate' to the relationship between the respondent and interviewer (Bowes and Domokos, 1994). This was evident in a few instances when respondents seemed to either be trying to give the 'correct' answer, the answer they thought I wanted to hear or did not answer a question at all. The danger here is that the interview process might collect public rather than private accounts (Cornwell, 1984). Conscious of this dilemma, I regularly reiterated to respondents that I was interested in their thoughts and experiences and that there was no right or wrong answer to any question. If it seemed that a respondent was giving a public rather than a private account I tried to rephrase questions and double check stories.

Another potential problem was that the quality of data collected can be influenced by characteristics such as gender, 'race', class and age. Henslin (1990), while researching homelessness in U.S. cities, found that differences in gender, 'race' or age between the interviewer and the respondent tended to make the researcher less acceptable to the respondent and the respondent less willing to talk. This problem was not obvious in my work and there was nothing I could do if it was. My approach was to be honest and open with respondents and to be myself. However, what was obvious was that it was typically much easier to establish a rapport with older people and women and more difficult with young men. Why is not clear, but despite some respondents initially being unresponsive, I succeeded in striking up a productive relationship with all 40 respondents. Problems communicating with respondents are important and relevant to any understanding of the data and were recorded along with other observations in field notes so that the context of the interview could be referenced when analysing data.

Having accessed and recorded the accounts of 40 homeless people on 45 hours of audio tape, the challenge was to then analyse the data.

2.7 Data Analysis.

Qualitative data analysis is the process of resolving data into its constituent components to reveal its characteristic elements and structure (Dey, 1993). There is no set formula to which analysis must conform, but the aim remains the same; to describe and classify phenomena and explore how concepts interconnect. Detailed and thorough description of the phenomenon being studied, what Geertz (1973) refers to as 'thick' description, reveals the context, intentions and meanings that organise events (Denzin, 1978). Classifying involves the development of a framework through which we can make intelligible the events being researched. Description and classification allow the integration of data and the exploration of regular, variable and unique connections between data, the end being the production of an account. Dey (1993) provides a helpful analogy, comparing qualitative analysis to completing a jigsaw puzzle. He describes the data as the seamless sequence from which we first cut out the bits of the puzzle in a way that corresponds to separate elements of the social reality we are exploring. The challenge is to then put these bits back together again to produce an overall picture.

In order to describe, classify and connect, I developed a systematic approach that involved familiarisation, categorisation, abstraction and interpretation. Familiarisation involved immersion in the data and was helped by the fact that, as sole researcher, I had carried out all 40 interviews and transcribed each interview from audio tape to verbatim text in order to make the data more manageable and accessible. Transcribing the interviews and reading the transcripts and field notes gave me a feel for the depth and detail of the data as a whole and allowed me to develop hunches regarding key themes and recognise emergent issues. In turn, this process assisted the development of a category framework.

Categorisation is the process of generating and applying a thematic framework to the data by attaching category names to basic units of research data (Pfaffenberger, 1988). The process involves putting all data that seems related or similar in the same group or category.

Continuing the jigsaw analogy, categorisation involves determining which bits make up the blue sky, the brown earth, the green of the forest and so on. In generating a category list I adopted a middle-order approach (Dey, 1993) which was a compromise between the line by line approach of grounded categorising (Strauss, 1987) and the broad brush approach of

categorisation based on general understanding (Jones, 1985). I already had a framework for generating middle order categories - the interview schedule - and was confident of the potential of these initial categories to organise the data. However, by adopting a semi-structured interview schedule I had acknowledged that I did not know all the relevant and unambiguous questions and could not make all the significant category distinctions at the start of the research. Therefore, as analysis progressed and I assigned categories to bits of data, I remained open to extending, modifying and disregarding categories as issues and distinctions emerged from the data and so developed a more detailed list of categories (see Appendix 4).

The generation and refinement of categories was undertaken in tandem with the assignment of categories to bits of data. Assigning categories is a two stage process. The first stage is to divide the data into bits. The second stage is to assign categories to bits. Creating bits involved the identification of what Dey (1993) refers to as, 'irreducible units of meaning' that are meaningful internally and with respect to analysis. When dealing with data in textual form a bit might be a part of or all of a sentence, a number of lines, a paragraph, a page or number of pages. However, when creating bits there is a need to balance the aim of not including too much data against the need to avoid too narrow an approach that would lose sight of the context. Assigning a category to a bit involves asking if there is a category that suggests itself, are there any other possible categories, does an existing category need refining or does a new category need to be created. Bits were defined and categories were assigned by going through the data in a systematic way. This involved going through each transcript and following the chronological sequence defined by the interview schedule. Concentration and judgement were the key tools.

After the defining of bits and assigning of categories, the focus shifted from the data in its original context to categorised data. Attention focused on sifting through bits assigned to each category and exploring regularities, variables and singularities in search of detail. The challenge was to then weave together the details in search of scope of understanding. Sifting and weaving involved identifying categories relevant to the main interests and objectives of the study and exploring comparisons within and linkages between categories. Charts were often drawn up to help with the visualisation of complex details. For example, many respondents had approached the local authority for housing without any success and their comments about their experiences were collected under the same category heading. However, on closer

examination, different people had their applications rejected for different reasons and had different experiences of the council housing service. Charting helped explore these variations. Headings and sub-headings were drawn up that reflected different experiences as captured in the categorised bits and allowed the cross reference of experiences within and between different cases. By exploring and comparing the patterning of events and experiences the research moved between sifting and weaving and developed associations and explanations. In this way an overall picture of the social reality under examination was built up.

Throughout the process of familiarisation, categorisation, abstraction and interpretation, computers were used to assist analysis. Qualitative strategies involve a 'cruel trade off' between the richness of qualitative data and the tedium of analysing it (Sproull and Sproull, 1982). Certain mechanical tasks in the management of the data have to be done before and in conjunction with analysis and abstraction (Tesch, 1991). Therefore, the rigour and accuracy of data management and the time taken affect the rigour, accuracy and time available for analysis. However, computer packages can help with these mechanical tasks, allowing data organisation and manipulation to proceed rapidly and smoothly and ensuring that the mechanics of research are less likely to get in the way of analysis (Lee and Fielding, 1991). For these reasons I used a computer package to assist with analysis. In deciding on a suitable package the key considerations were availability and appropriateness. Financial restrictions and resource availability limited choice to word processing programs and three packages designed to assist qualitative data analysis - NUDIST, Hypersoft and The Ethnograph. Choice was further restricted by the need for a system that would allow the categorisation and retrieval of semi-structured textual data. I had to be able to mark and retrieve sections of text at ease and explore connections by cross referencing retrievals. Given these demands, and the fact support was readily available because the system was developed at Edinburgh University, the Hypersoft program was the most suitable package.

Using Hypersoft involved investing research time in learning how to apply the package but this took no more than a few days and once I was familiar with the system it provided an environment and set of tools that allowed quick, thorough and efficient analysis of data. Data was imported in text form from a Word for Windows file and a category list was entered into the program. The program then allowed me to go through the complete data set defining bits of data and assigning categories by simply highlighting the appropriate text and clicking on

the relevant category. The categorised bits were stored separately from the interview data, were available for viewing and could be re-categorised and subcategorised.

Once the data had been categorised numerous procedures were available to assist exploration of the data, including retrieving, linking and mapping. Retrieving involved unconditional searches (for example, for all data categorised under a specific category heading) and conditional searches (for example, of all data categorised under two specific categories or all data assigned to a specific category within a particular case, such as all women of a certain age). As analysis progressed and more comparisons were made and patterns explored, so retrievals became increasingly complex. Hard-copies of each retrieval were printed out and using personal judgement, concentration and a pen and paper I mapped out emergent issues and explored key research questions.

The principal benefit I gained from using a computer package to assist with analysis was that more of my energy was directed toward analysis rather than the mechanics of handling the data. Assigning categories and making connections was made quick and easy. I was able to develop and handle a complex collection of categories and explore emerging concepts with constant reference to the data. The speed and ease of handling data increased rigour without sacrificing openness to the complexities of experience and behaviour. The full breadth and width of the data could be explored, allowing both rich, suggestive and specifically relevant experiences to emerge. The process was, consequently, less impressionistic than if I had relied on repeated trawling through the transcripts. However, there were a number of potential problems with the use of computer packages designed to assist qualitative analysis that had to be addressed.

A major problem when using computer packages designed to assist qualitative analysis is the tendency to become fascinated with volume. The computer package allows the researcher to handle larger and larger data sets with relative ease (Seidal, 1991). The danger here is that the computer packages might wipe out the qualitative/quantitative dichotomy, qualitative research becoming driven by volume rather than detail and the time and energy of the analyst being spread across many cases. Conscious of the temptation to sacrifice resolution for scope, I worked with a data set the size of which was determined by what I could collect and analyse,

rather than what the computer could handle. I used the computer to help me analyse phenomena rather than count the occurrences of these phenomena.

Another problem with the use of computer packages in qualitative analysis is that the package might start to guide the research design. In my experience, faced with a large data set and not knowing where to start, the computer package gave structure to the seemingly unformulated madness of qualitative research. The danger here is that research design and analysis could become guided by technology as researchers design projects to fit computer programs (Richards and Richards, 1991). I responded to this problem by viewing the computer package as a mechanical tool to be used how and when I wanted, rather than a methodological blueprint. Viewing the package as a mechanical tool led me to the realisation that computer technology has a use in qualitative data analysis but does not have to be used. For example, the package was designed to assist with (not direct) the exploration of links and patterns, in a way analogous with cross-tabulations in quantitative survey analysis packages. However, because I felt that by using the package to assist with abstraction I would lose sight of the context of particular experiences and the significance and complexity of the data would be reduced, I chose to limit use of Hypersoft to handling coded data and carrying out retrievals.

A concern with the increasing use of technology in qualitative studies is that research and data analysis may come to be determined by the technology (Seidal, 1991). This is a concern that I became aware of through my use of Hypersoft. However, in my experience, the problems of using computers to assist with qualitative analysis can be limited if they are acknowledged and research can reap significant benefits from utilising technology when it suits practical and theoretical demands.

2.8 Summary

As I pointed out at the beginning of this chapter, any methodology is necessarily an interplay of various demands and considerations. What I have tried to do in this chapter is outline the demands and considerations I had to contend with in this study and show how they shaped data collection and analysis. Semi-structured interviews with single homeless men and women with health problems who were living in various circumstances and situations provided rich and detailed data. Analysis of the data involved familiarisation, categorisation, abstraction and

interpretation and provided an insight into the lives and experiences of respondents. The following chapters will discuss these insights in detail.

THE HEALTH OF HOMELESS PEOPLE: MOVING THE INVESTIGATION FORWARD.

Homeless people experience a high incidence of mental and physical health problems compared to the general population. However, a comprehensive explanation for the poor health profile of homeless people has yet to be provided. The aim of this chapter is, first, to describe the health profile of homeless people and, second, to expand on two kinds of explanation that could account for this health profile which were introduced in Chapter One.

In describing the health profile of homeless people I review previous research and discuss the health of the 40 homeless people interviewed in this study. Introducing two kinds of explanation that could account for the poor health profile of homeless people, I first examine the neglected and highly controversial issue of health selectivity out of and into the housing system. A consequence of the lack of information on the health histories of homeless people is that little is known about the health status of homeless people *before* they became homeless. It has, therefore, hitherto been difficult to specify the extent to which the health profile of homeless people is a product of people with health problems becoming homeless. My data, however, contain information on the health experiences of homeless people before they last became homeless. This allows me to explore the possibility that the health profile of homeless people is, at least in part, a product of health selectivity out of and into the housing system and that this controversial issue warrants attention.

Second, I consider the impact of homelessness on health. This explanation assumes that health deteriorates as a result of being homeless, and is the focus of existing attempts to understand and respond to the poor health profile of homeless people. Most attempts to support this claim are based on cross-sectional data. My data, however, contain longitudinal information on the

health histories of homeless people that shows what changes, if any, people have experienced in health status since becoming homeless and will help us better appreciate the extent of the impact of homelessness.

3.1 The Health Profile of Single Homeless People.

3.1.1 Previous studies of the health of homeless people.

Research into the health of homeless people has traditionally focused on the prevalence of disease (recognisable physiological and psychiatric disorder) among single men living in short and long stay hostels and lodging houses or attending specialist health care services for people who are homeless. These studies have recorded high incidence rates of a range of mental and physical health problems among their sample populations. More recently, as the number of homeless people has increased and the visible signs of homelessness have become more apparent on the streets of Britain's towns and cities, some studies have widened their focus and recognised the diverse character of the homeless population and the different circumstances and situations in which homeless people are living. These studies of the wider homeless population have also recorded high incident rates of physical and mental health problems. Although incident rates among homeless people have typically been compared to incident rates among the general population, rather than against a comparable sample of the housed population (age, social class, lifestyle), it is widely accepted that a range of mental and physical health problems are more common among the homeless population.

Physical health

Early studies tended to concentrate on physical illness and revealed high rates of infectious disease, in particular tuberculosis, among the male hostel population (Laidlaw, 1956; Elwood, 1961; Joint Tuberculosis Council, 1965; Scott et al., 1966; Gaskell, 1969). The incidence of tuberculosis amongst this population has continued to be an issue of concern as variable, yet consistently high rates of infection have been recorded (Caplin, 1978; Shanks and Carroll, 1982; 1984; Patel, 1985; Capewell et al., 1986; Toon et al., 1987; Featherstone and Ashmore, 1988; Ramsden et al., 1988; Wosornu et al., 1990; Stevens et al., 1992, Shanks et al., 1994). Tuberculosis has been reported as more advanced and more common in male hostel dwellers

(Shanks and Carroll, 1984) who have been recognised as a potentially dangerous reservoir of active pulmonary tuberculosis (Patel, 1985). Other common themes regarding the physical health of single men sleeping rough and living in hostels have been the experience of chest problems such as bronchitis and emphysema, dermatological problems, physical disability, musculoskeletal problems, genito-urinary problems and a range of problems related to alcohol and drug dependency (Gaskell, 1969; Powell, 1987; Toon et al., 1987; Ramsden et al., 1989; Kelling, 1992).

Unfortunately, information on the incidence and experience of physical health problems among homeless women remains sketchy. Few studies have focused on the health of homeless women. Why is not clear. That there are far fewer women than men among the single homeless population is more an excuse than an explanation. It is more likely that the typical stereotyping of homeless people as socially isolated men, suffering from personality disorders, with a high incidence of alcoholism and residing in common lodging houses has denied the reality of the lives of thousands of women living in hostels, sleeping rough, sharing with friends or staying in temporary accommodation. Much of the information that is available on the physical health of homeless women comes from anecdotal accounts of the experiences of families living in temporary accommodation. Infectious disease, gastro-enteritis, problems during pregnancy and high rates of post-natal and clinical depression have been reported (Drennan and Stearn, 1986; Stearn, 1986; Conway, 1988; Furley, 1989; Lowry, 1989; Lee and Goodburn, 1993).

A number of recent studies have attempted to widen debate through larger scale surveys of both homeless men and women. Bines (1994) analysed data on the health of more than 1500 homeless people (14% of who were women) living in hostels, bed and breakfast 'hotels' or sleeping rough throughout England. The incidence of chronic chest or breathing problems, dermatological problems, musculoskeletal problems, difficulties seeing, fits or loss of consciousness, digestive problems and frequent headaches were found to be two or three times higher amongst these homeless men and women than the general population as recorded in the British Household Panel Study. Shanks (1988) based conclusions on some 2500 homeless people (100 women) who were examined over a three and a half year period. Compared to the general population, higher than usual incidence rates of communicable, genito-urinary,

dermatological, haematological and psychiatric diseases were recorded amongst the homeless people examined.

Problems of sampling, controlling and ensuring data consistency continue to make useful comparisons between studies of the health of homeless people difficult (Shanks, 1981). Consequently, differences of opinion exist as to the range and incidence of physical health problems amongst the homeless population. However, it is accepted that homeless people are much more likely to be experiencing acute physical health problems than the general population.

Mental health

In recent years concern has mounted over the incidence of mental health problems amongst people who are homeless. This is in part a result of the increased visibility of homelessness on the streets of Britain's towns and cities and in part a result of growing concern over the fate of people discharged into the 'community' under the auspices of community care. Early studies of the mental health of homeless people focused on the mental health of men in reception centres, lodging houses and hostels. These studies served to heighten awareness amongst concerned professionals of the disproportionate experience of mental health problems, illness and disability among these homeless people (Edwards et al., 1968; Lodge-Patch, 1971; Priest, 1971; Tidmarsh and Wood, 1972). Recent studies of the male hostel population have confirmed these early reports. Variable, but consistently high levels of personality disorder, schizophrenia, drug dependency, alcohol dependency, depression and a history of psychiatric illness have been reported (Weller, 1986; Weller et al., 1987, Timms and Fry, 1989; Weller, 1989; Garety and Toms, 1990).

Typically, as with studies of physical health, studies of the mental health of homeless people have focused on the problems of single destitute men (Marshall and Reed, 1992). The little evidence that has been available on homeless women and their mental health status suggests that homeless women are disproportionately susceptible to psychiatric morbidity compared to the general population (Berry and Orwin, 1966; Herzberg, 1987). More recent studies of the mental health of homeless people have increasingly reflected the heterogeneity of the homeless population. Marshall and Reed (1992) assessed the health of 70 women from two hostels in

inner London. They found that 60% had been admitted to a psychiatric hospital at some time and that 47 of the 70 showed signs of schizophrenia. Although recognising that the recorded incidence rate of schizophrenia may be high because of bias in their sampling, Marshall and Reed conclude that there are high levels of psychiatric morbidity among homeless women. Geddes et al. (1993) and Geddes et al. (1994) assessed the health of some 200 men and women living in hostels and sleeping rough in Edinburgh. High levels of previous psychiatric institutionalisation and psychiatric disorders such as schizophrenia, depressive illness and substance abuse were recorded amongst both men and women living in hostels and sleeping rough.

Although estimates of the nature, extent and severity of mental health problems vary considerably, reflecting problems in sample selection, methods of investigation and case definition (Marshall and Reed, 1992), recent studies have confirmed earlier conclusions. Significant levels of mental health problems and illness - functional psychoses, acute distress, personality dysfunction, eating disorders and co-morbidity of mental illness and substance abuse - have been recorded amongst homeless men and women (George et al., 1991; Gard and Freeman, 1992; Marshall and Reed, 1992; Geddes et al., 1993; Scott, 1993; Geddes et al., 1994; Newton et al., 1994).

The notion of health is a complex concept involving lay person and health sector perceptions, set within the context of the socio-economic environment. However, disease (the organic dimension of health) has remained the focus of research into the health of homeless people. Little or no attention has been paid to the functional and social dimensions of health. Similarly, the notion of homelessness is a complex concept. Many different people, living in various circumstances and situations, are homeless in Britain today (see Chapter Five). Studies of the health of homeless people have glossed over this diversity and have focused on the health of men living in hostel accommodation or sleeping rough. The health profile and health service needs of the male hostel dweller have been taken as representative of all homeless people. Despite these key inadequacies and the questions they raise about the accuracy, validity and representativeness of information on the health profile of homeless people, studies of the health of homeless people have been accepted as evidence that homeless people are more likely to suffer from severe mental and physical health problems than the general population.

3.1.2 The health profile of 40 homeless people in Edinburgh.

For the purpose of the present study, data were collected on the current health status of 40 respondents by implementing the health related quality of life questionnaire that was incorporated into the interview schedule (see Chapter Two). The questionnaire was designed to be sensitive to the organic, functional and social dimensions of health and provide data on respondents diagnosed and self reported health status and the impact of health on their everyday life and role in society.

The common health themes that emerged from the interviews reflect the findings of previous studies of the health of homeless people. A wide range of, often severe, mental and physical health problems are apparent among the 40 respondents. Incident rates are high and coexistence of two or more problems is the norm.

Self reported health status

When asked to describe what they thought of their present state of health on a grading from excellent through good, average, poor to very poor, only seven respondents replied poor or very poor. This figure only increased to 12 when respondents were asked what they thought of their health compared to other people of their age. However, when asked if there was anything wrong with their health, 37 of the 40 respondents referred to one or more health problems they are currently experiencing.

The range of physical and mental health problems respondents reported reflect the common themes to emerge from previous studies of the health of homeless people. The most common self-reported health problems are anxiety/nervousness/stress, followed by aching joints and muscles, sleeping problems, respiratory and chronic chest problems, manic/suicidal depression, walking problems and lethargy/exhaustion (Table 3.1). A similar range of problems are experienced by men and women and across all age groups.

The coexistence of more than one problem is a common experience among both male and female respondents, although women typically self-reported fewer problems than men. Thirty-three (33) out of the 37 respondents who are experiencing current health problems reported

Table 3.1 The range and incidence of physical and mental health problems reported by respondents.

<u>Health problem</u>	<u>Number of respondents reporting problem.</u>		
	Women (n=13)	Men (n=24)	Total (n=37)
Respiratory/chronic chest problems	2	6	8
Dermatological problems	1	2	3
Loss of consciousness	-	3	3
Sleeping problems	3	7	10
Heart problems	-	2	2
Digestive problems	1	2	3
Genito-urinary problems	1	3	4
Constant flu/colds	1	2	3
Aching joints and muscles	3	8	11
Severe headaches/migraines	1	3	4
Walking problems	-	5	5
Difficulty seeing	-	1	1
Lethargy/exhaustion	1	4	5
Diabetes	-	1	1
Flashbacks	-	2	2
Eating problems/disorders	2	2	4
Schizophrenia	-	1	1
Epilepsy	1	-	1
Alcohol dependency	1	5	6
Drug abuse/dependency	-	1	1
Anxiety/stress/nervousness	8	13	21
Manic/suicidal depression	4	2	6
Learning/behavioural difficulties	2	2	4
No problems	2	1	3

(Number of respondents = 40)

experiencing two or more problems. Eleven (11) respondents reported experiencing four or more different problems (Fig 3.2). No one health problem predicts the coexistence of other specific problems and each respondent reported a unique combination of problems. However, the five respondents who have a problem with alcohol use are all experiencing additional

problems, including respiratory, genito-urinary and muscoskeletal problems, which seems to support evidence that alcohol abuse among homeless people is an important risk factor for a number of other health problems (Vredovoe et al., 1992). Also, the four respondents who have a problem with drug use are all experiencing additional problems, including lethargy, flashbacks and depression.

Table 3.2 The coexistence of self reported health problems.

<u>Number of problems experienced</u>	<u>Woman</u>	<u>Men</u>	<u>Total</u>
0	2	1	3
1	2	2	4
2	4	7	12
3	5	6	11
4 or more	2	9	11
Total	15	25	40

Diagnosed health status.

When asked if they have any health problems diagnosed by a health professional, 34 respondents (12 women and 22 men) referred to one or more problems. The range of diagnosed mental and physical health problems reflects the common themes to emerge from the self-report assessment. The most commonly diagnosed problems are anxiety/stress, followed by aching joints and muscles, manic/suicidal depression, respiratory and chronic chest problems, alcohol dependency and walking problems (Table 3.3). There are some differences between the range of diagnosed problems experienced by men and women. Specifically, the women interviewed do not have as wide a range of diagnosed physical health problems. Why is not clear, although the fact that fewer of the women interviewed have been exposed to the harsh physical environment of sleeping rough may be significant (the potential impact of sleeping rough on health is discussed in Chapter Four).

Nineteen (19) respondents reported the coexistence of two or more diagnosed health problems (Table 3.4). As with self-reported health, no one diagnosed problem predicts the coexistence

Table 3.3 The range and incidence of diagnosed health problems.

<u>Health problem</u>	<u>Number of respondents with diagnosed</u>		
	<u>problem</u>		
	Women	Men	Total
	(n=12)	(n=22)	(n=34)
Respiratory/ chest problems	2	3	5
Dermatological problems	1	1	2
Loss of consciousness	-	3	3
Sleeping problems	1	2	3
Heart problems	-	2	2
Digestive problems	1	2	3
Genitourinary problems	1	1	2
Constant flu/colds	-	-	-
Aching joints and muscles	1-	6	7
Severe headaches/migraines	-	2	2
Walking problems	-	4	4
Difficulty seeing	-	1	1
Lethargy/Exhaustion	-	1	1
Diabetes	-	1	1
Flashbacks	-	1	1
Eating problems/disorder	-	-	-
Schizophrenia	-	1	1
Epilepsy	1	-	1
Alcohol dependency	1	4	5
Drug abuse/dependency	-	-	-
Anxiety/stress/nervousness	8	3	11
Learning/behavioural difficulties	5	1	6
Manic/suicidal depression	1	4	5
No problems	3	3	6

Number of respondents = 40

of another specific problem and each respondent reported a unique combination of diagnosed problems. However, problems with alcohol use again coexisted with at least one other

problem.

The number of respondents with two or more diagnosed health problems (19) is significantly down on the 33 respondents who are aware of experiencing two or more health problems (Table 3.2). A discrepancy between the incidence of self-report and diagnosed health problems is not surprising. Self awareness of a health problem will not always match medical diagnosis. A person can be aware of a health problem that a medical professional would not recognise as a physiological or psychological disorder and a person can be diagnosed as suffering from a recognisable disorder but be unaware they have a problem. However, the discrepancy between the incidence of self-reported and diagnosed health problems cannot be explained away by assuming that respondents are either conscious of problems that are not recognisable physiological or psychological disorders or have not had their health assessed by a medical professional. No respondent has approached the health service with a problem and been told it is not a recognisable disorder and 31 respondents are currently permanently or temporarily registered with a GP and believe they can access a GP if needs be. Rather, the difference between self-reported and diagnosed health is the product of a complex relationship between respondents' awareness of their health status and their utilisation of available health care. This relationship will be discussed in detail in Chapter 4, suffice to say here that the discrepancy is not a consequence of respondents self-reporting problems that do not exist but of respondents not receiving comprehensive health care.

Table 3.4 The coexistence of diagnosed health problems.

<u>Number of diagnosed problems</u>	<u>Women</u>	<u>Men</u>	<u>Total</u>
0	3	3	6
1	8	7	15
2	2	10	12
3	1	3	4
4 or more	1	2	3
Total	15	25	40

The difference between respondents' self-reported and diagnosed health is an important finding. Studies of the health of homeless people tend to focus on medically diagnosed, physiological and psychological disorder. The discrepancy between diagnosed and self-reported health problems in this study suggests that focusing on recognised disorders denies the full extent of the poor health profile of homeless people. This suggestion is reinforced by the detailed data that were collected on the functional and social dimensions of respondents' health.

The functional dimension of health - the impact of health on everyday life

Health problems can have a major and persistent impact on everyday life. Difficulties getting out and about, undertaking physical tasks and problems interacting and mixing with people, for either physical or mental health reasons, are all ways in which health can impact on life. Twenty-four respondents (seven women and 17 men) reported that their health restricts what they can do. Ten (10) respondents have problems getting about because of physical health problems, including muscoskeletal, heart and respiratory problems, that are persistent and static and amount to some degree of physical disability. All 10 of these respondents are men, eight are aged over 40 years old and all have been homeless for more than one year. 'I can't walk these hills' was a common response when these 10 respondents were asked whether their health impacts on their day to day life. Charlie, a 65 year old man suffering from heart problems, bronchitis and suicidal depression, has severe problems getting about:

DR - OK. Do you think that your health affects what you can do day to day?

CHARLIE - I think so. You know in this area especially. It is pretty hilly and a lot of stairs round about, I try to avoid them. If I tried to go up this road and up them stairs I would not make it to the top. I did try it last week and I got up to, I was going to the DSS and it took me about 10 minutes and that was taking a short cut and I was in some state when I got up there.

PSP7

Robbie is 68 years old and is suffering from alcohol dependency, physical disability, arthritis, sleeping problems and kidney problems. Robbie has difficulties getting about that are undermining his confidence and make him dependent on the help of other people:

DR -what do you think about your present state of health?

ROBBIE - It's no good. I am weak walking. I am worse off walking than I am talking. I am shaky, dodgy. My pelvis, I fractured that in a fall.

DR - Do problems walking restrict what you can do?

ROBBIE - Oh, definitely yes. I have lost all confidence in myself. I am ex-navy. Royal navy for 16 years. I used to be full of life. I used to be full of joy, jumping about like a but I can't do it now.

DR - Do you have difficulty getting around?

ROBBIE - I do. It's very seldom that I leave here (hostel) much at all. It's true....

DR - Do people treat you different because of your health?

ROBBIE - Oh, of course but you have just got to grin and bear it, well like I told you I have been in here about nine years. That's what I'm saying. I wouldn't take a place of my own 'cause I wouldn't have the confidence. I wouldn't be able to retaliate if anything happened or anything, you ken?

PSP1

Mental health problems also impact on respondents' everyday life. All five respondents suffering from lethargy and/or exhaustion, problems that might commonly be dismissed as minor ailments, talked about how their condition has a major impact on their lives. Les, a 42 year old man is suffering from a number of problems including depression and lethargy:

DR - Do you have any times of feeling worried or being down?

LES - The last fortnight I went to sign on and I just couldn't be bothered getting up. They gave me the forms to fill in and I just couldn't be bothered filling them in. Some of these days I just canna be bothered doing anything.....sometimes it gets you and you canna be bothered doing nothing. Sitting in here (hostel) all day you get fed up, you just have to try and get out.

PSP4

Cameron, a 21 year old man, is suffering from lethargy, sleeping problems, flashbacks and paranoia, which he relates to a history of drug abuse. Cameron is having difficulties getting out and talked about feeling lazy:

DR - At the moment is there anything wrong with your health?

CAMERON - Not that I know of.

DR - Have you any aches or pains?

CAMERON - No, just laziness. Sometimes I can't be bothered. I used to take a lot of E (ecstasy) and Acid and that, and that just mucked up my sleeping habits and there was one point where I couldn't sleep at night....

DR - Does that affect your day to day life?

CAMERON - Sometimes I just sit in my room all the time and don't go out. I want to go out but there's just something at the back of my head saying no.

BDG2

The six respondents suffering from manic or suicidal depression also talked about how their health limits what they do. Sandra is 38 years old and is suffering from suicidal depression, exhaustion and aching joints and muscles. Sandra often struggles to get out of bed and out of her accommodation and feels that health problems have shattered her life:

DR - Does your health affect your day to day life in anyway?

SANDRA - Oh, definitely, your whole life. It's like opening a window and throwing the whole lot out. Throwing your whole life out the window and shutting the window and you have just got to stay there until you get better and I am slowly getting better but I still don't know. I had my life planned before it (depression) happened to me. I planned to do this that and the other but that was away, everything changed.

SFD1

Clearly, health problems, some of which may be dismissed as minor ailments, are having a severe impact on what respondents are *able* to do. Respondents also reported that health problems are restricting what they are *allowed* to do.

The social dimension of health - impact of health on role in society.

Twenty-three (23) respondents said that their health affects what they are allowed to do, either impacting on employment opportunities, relationships with friends, relatives and others or restricting their freedom.

Employment opportunities - Eighteen (18) respondents said their health limits employment opportunities because of the unwillingness of employers to offer or keep them in work. However, only 12 respondents (three women and nine men) are in receipt of invalidity or sickness benefit, state recognition that an individual's health restricts their ability to work or gain employment (as of April 1995 invalidity and sickness benefit have been replaced by incapacity benefit). All three women and three of the nine men in receipt of invalidity or sickness benefit said that the state had recognised they are unable to work because of mental health problems. The other six said physical health problems are the reason they are in receipt of invalidity or sickness benefit, although three of the six are also suffering from mental health problems.

Some respondents have lost work because of their health. Gill is 20 years old and suffers from alcohol dependency and suicidal depression. Gill's health was directly responsible for her losing a series of jobs:

DR - Do you think that your health problems affect you day to day life in any way?

Gill - Aye.

DR - In what way?



Gill - I have lost every job that I have had through drink. I am no a happy person with the drink and that can cause problems with the people you are with, like at work, and I have to leave.
BDG3

Gill is not in receipt of invalidity or sickness benefit. Charlie is 65 years old and is suffering from heart problems, bronchitis and suicidal depression. Charlie was told that he would have to give up work permanently following two heart attacks:

DR - Do you think that your health affects the way that people treat you?
CHARLIE - Oh yeah. I was doing, although I was the second chef in the job, I used to all the sweets and all the afternoon tea stuff so I did quite a bit of baking and as well as that I would be working at a range and the biggest danger is if I was shifting pots over to the hot plates for service I could fall or anything, so they explained it to me and they were right. It had to happen. I had to give it up.
PSP7

Subsequently, Charlie has been in receipt of invalidity benefit. Pat is a 28 year old woman suffering from epilepsy, constant flu and colds and a back problem. Pat also lost her job because of health problems:

PAT - Well, before I actually went on medication I was taking 15 to 20 fits a week and I took one at work, and the doctor said 'we have to get you sorted out quickly' so I left and was put on the sick and I haven't been able to go back to work since.
CST5

Since leaving work Pat has been on invalidity benefit. She has worked closely with her doctor and together they have stabilised her condition. She has since been advised to start looking for work again. She had been doing voluntary work five days a week for a number of months but has not been able to find employment. Pat believes that no employer will take her on because of her health:

PAT - I put in for a few applications for jobs and that 'cause the doctor was saying experiment if you can go back to work and there was a few employers once they had seen I had epilepsy wasna interested. Some people sort of look at you as if you have got a disease or something....
CST5

Other respondents have also experienced problems gaining employment because of health problems. Davie, is 37 years old and is partially sighted, suffers from blackouts, bronchitis, sleeping problems, varicose veins and a problem with alcohol use. Davie recently started

receiving invalidity benefit. Previously he had be unsuccessful in his attempts to find work and believes this was because of his health:

DR - You said earlier that you are on invalidity, why is that?

DAVIE - I am blind in one eye and I canna get another job. As soon as I get a form for a job and they ask you if there is anything wrong with you you have got to put it down because you get checked out anyway and as soon as they know that you've got a bad eye you're too much of an insurance risk so they'll just say we'll get in touch with you so I told them at the social and the social checked me out. I got told to go to their doctor, they checked it out and I got invalidity right away.

ADC8

Mick is 51 years old and has a leg problem that gives him difficulties walking and suffers from constant colds and flu. Mick talked about problems gaining employment because of his walking problems:

DR - You said something about your leg?

MICK - Well, it stops me working in the winter time 'cause I can't get about right.

DR - Why is that?

MICK - I was working on a fishing boat and the wire rope snapped and crushed me knee so I have got metal pins and I have got steel plates, yu know, and in the winter time the cold air and the dampness slows the blood circulation down so that's why it stiffens up and they say am no use, they won't take me on.

CDC3

Mick is not in receipt of invalidity or sickness benefit.

Freedom - Five respondents talked of how their health problems threaten or limit their personal freedom. These five respondents have all at some time been 'sectioned' or put in an institution against their will because of mental health problems under the Mental Health Act 1983 and regard institutionalisation as an ever present threat to personal freedom.

Annie is 45 years old and is suffering from manic depression, bronchitis, genito-urinary problems and a weight problem. Annie has previously been sectioned and is worried that there is a real chance she could be sectioned again if she steps out of line with her social worker and psychiatrist. Her social worker and psychiatrist are happy with her current condition and situation and Annie fears that moving out of the hostel could disturb the status quo. Consequently she feels trapped. Harry is 50 years old and is suffering from schizophrenia. Harry has been sectioned in the past and is afraid of being sectioned again if he steps 'out of line':

HARRY - Well, I am a schizophrenic jon. I am on injections and tablets and that dopes you up and your mind is not alert and you are on tranquillisers and you have got to stay on them and if you come off, if you try to come off they'll burl (throw) you in the nick 'cause if you step out of line outside you're huckled (hassled) and if they find you are not taking your medication you're away....
CDC5

Cathy is 28 years old and suffers from manic depression. Cathy has been institutionalised a number of times in recent years. Although she recognises that institutionalisation might at times be a necessary part of her treatment, she is also conscious of the loss of freedom that it involves:

DR - At the moment is there anything wrong with your health?
CATHY - Well, I have been diagnosed manic depressive, so obviously I have got that to cope with. I have been in and out of hospital in the last 18 months four times and this time is the only time that I have been stable. The last time I got out of hospital was September (four months previous) and I have been stable since but it's just a gamble with the drugs. It could be just a good period that I'm going through or it could be just the drugs working. They don't know so I have got that to think about, I could be away and back in whenever. It's a worry 'cause it's no fun!
ADC1

Relationships with family, friends and others - Eleven respondents said that their health impacts directly on their relationships with family, friends and others, affecting their ability to fulfil their role in the family, affecting how people treat them and damaging relationships.

Carol is 27 years old and is suffering from behavioural problems, sleeping problems, dermatological problems and anxiety/stress. Carol was forced to leave home after her relationship with her mother deteriorated to the extent that her mother threatened her with legal action:

DR - You said that you are trying to work out why you are the way you are, what do you mean by 'the way you are'?
CAROL - No, I have been taking mood swings, burleys, breaking up things and my mum was actually going to get an interject (injunction) out on me for doing these things.

Carol feels torn between going back to her mother and breaking away completely because of problems caused by her health:

CAROL - I am half wondering, 'cause it is hard to find peace, if I'm, if I am going to be with my mum or if I'd feel better to be away completely and to find my own life completely. These are the things that I am weighing up at the moment.
CST7

Some respondents feel that people underestimate their abilities, are patronising and pay them too much attention because of their health problems. Cathy feels that because friends are aware that she is suffering from manic depression and has been institutionalised they treat her differently:

DR - Do you think that your health affects the way that people treat you?
CATHY - Sometimes yeah. I sometimes think that people underestimate me 'cause a lot of people have known me for a long time and because I go through such highs and the way I act and that they always, or sometimes get the feeling that I was off my head or not all there, away with the fairies so I find it hard 'cause people act different, 'cause I have never had a full time job or that they look at me and go aye right, never mind.
ADC1

Willie is 20 years old and has been diagnosed as suffering from a personality disorder and is experiencing anxiety, scabies and a knee problem. Like Cathy, Willie believes that people treat him different if they are aware of his health problems:

DR - Do you think that your health affects the way that other people treat you?
WILLIE - Aye.
DR - How?
WILLIE - Well, I just think, most people if they think you are mental they treat you like an idiot. Social workers and that, they always say one thing to me and mean the other. I have talked to the social workers since I was seven and by the time I was 14 I began to suss it out. At first when I was 16 that social worker put a thing in with the council saying that she didn't think I was fit enough to look after a house so they wouldn't give me one and at the same time they are turning round and saying that there's fuck all wrong with me, so why did she do that? It's best they don't know.
ADC 7

Clearly, health problems are having a significant impact on what respondents are allowed to do.

3.1.3 Summary

Studies of the health of homeless people provide evidence that homeless people experience a high incidence of mental and physical health problems. The health of the 40 homeless people

interviewed in this study offer further confirmation of this conclusion. However, data collected on respondents' self awareness of health problems and the impact of health on everyday life and role in society suggest that the full extent of the poor health profile of homeless has been under-estimated by the failure of research to look beyond the organic dimension of health. Respondents are aware of many, often severe health problems, that have not been diagnosed by a health professional and data on respondents social and functional health suggest that problems, some which might be dismissed as minor ailments, are having a significant impact on their lives.

Having described the health profile of homeless people, I will outline and evaluate two key explanations for this profile.

3.2 The Relationship in Time Between Homelessness and Health.

The aim of this study is to move analysis of the health of homeless people on from describing the health profile of homeless people to understanding its determinants. In Chapter One I argued that the medicalisation of the health of homeless people has diverted attention away from policy areas other than health services that should be addressing the poor health profile of homeless people, and I suggested two plausible explanations for this poor health profile. The two explanations are, first, that the physical and servicing environments of homelessness are hazardous to health and, second, that people with health problems are unable to secure and maintain a position in the restructured housing system. In Chapter Two I argued that in order to assess the validity of these two explanations it is first necessary to explore the relationship in time between homelessness and health. This is what I will do in the remainder of this chapter. First, I will discuss respondents' health before they became homeless. If respondents had health problems before they became homeless then it is logical to infer that the poor health profile of homeless people is, in part, a product of people with health problems becoming and remaining homeless. Secondly, I will discuss what changes in health respondents have experienced since becoming homeless. If respondents have experienced a deterioration in health since becoming homeless then it is possible that the poor health profile of homeless people is, in part, a product of homelessness being hazardous to health.

3.2.1 Are people with health problems becoming homeless?

By integrating recall techniques into the health related quality of life questionnaire, data were collected from 30 of the 40 respondents regarding self-awareness of health problems, diagnosed problems and the impact of health on everyday life and role in society before becoming homeless. Ten respondents were not questioned about their health before they became homeless because they had been homeless many years (in some cases over 20 years) and recall was not possible over such a large time span. Respondents did not talk in as much depth about the impact of health on everyday life and role in society before becoming homeless as they had done when referring to their current health, but still provided a detailed account of their health status before they became homeless.

Of the 30 respondents questioned about their health before becoming homeless, 20 recalled health problems diagnosed by a health professional, 25 recalled being aware of health problems and 18 respondents recalled ways that their health had impacted on what they were able and allowed to do. The mental and physical health problems respondents were experiencing before becoming homeless reflect many of the common themes to emerge from previous studies of the health of homeless people. Respondents recalled problems as varied as heart problems, learning difficulties, manic and suicidal depression, blackouts and chronic respiratory problems. This is an important finding. That respondents were experiencing, often severe, health problems before they became homeless is evidence that the poor health profile of homeless people is, in part, a product of people with health problems becoming homeless.

Self-reported health status

When asked to describe the state of their health before becoming homeless on a grading from excellent, through good, average, poor, to very poor, 14 respondents replied excellent or good, five average and six poor or very poor (five offered no answer). However, when asked if there was anything wrong with their health before last becoming homeless 25 respondents (11 men and 14 women) recalled experiencing one or more health problems.

Respondents reported experiencing an extensive range of problems before they became homeless. The most commonly reported problem was anxiety/stress, followed by

manic/suicidal depression, learning difficulties/behavioural problems, musculoskeletal problems, respiratory problems and exhaustion/lethargy (Table 3.5). A similar range of problems were recalled by men and women across the ages, although men recalled a wider range of physical health problems and the only respondents recalling problems with drug use were less than 30 years old.

Table 3.5 The range and incidence of health problems respondents were experiencing before becoming homeless.

<u>Health Problem</u>	<u>Number of respondents experiencing problem.</u>		
	Women (n=14)	Men (n=11)	Total (n=25)
Respiratory/chronic chest problems	3	1	4
Loss of consciousness	-	2	2
Sleeping problems	3	-	3
Heart problems	-	1	1
Digestive problems	1	1	2
Aching joints and muscles	1	2	3
Severe headaches/migraines	-	2	2
Lethargy/exhaustion	1	3	4
Alcohol dependency	1	-	1
Drug abuse/dependency	-	3	3
Anxiety/stress/nervousness	5	5	10
Manic/suicidal depression	3	2	5
Learning difficulties/behaviour probs	2	3	5
No problems	1	4	5
Number of respondents = 30			

Thirteen (13) of the 25 respondents who recalled experiencing health problems before last becoming homeless were suffering from two or more problems (Table 3.6). There was no one experience of coexistence, each person reporting a unique combination of problems. However, all three respondents who had a problem with drug use were also experiencing mental health problems (depression, anxiety, nervousness and/or paranoia).

Table 3.6 The coexistence of self reported problems before becoming homeless.

<u>Number of problems experienced</u>	<u>Women</u>	<u>Men</u>	<u>Total</u>
0	1	4	5
1	8	3	11
2	2	3	5
3	3	2	5
4 or more	1	3	4
Total	15	15	30

Diagnosed health status.

Twenty (20) of the 30 respondents questioned about their health status before becoming homeless said they had suffered from health problems that had been diagnosed by a health professional as a recognisable disorder. These 20 respondents (10 men and 10 women) recalled a wide range of diagnosed health problems (Table 3.7). Most common were learning difficulties/behavioural problems, followed by manic/suicidal depression and respiratory problems. The range of diagnosed problems was not as extensive as the range of problems respondents recalled being aware of before they became homeless. Drug abuse, lethargy/exhaustion, muscoskeletal problems and loss of consciousness are all problems respondents recalled being aware of before becoming homeless but had not been diagnosed as recognisable disorders by a health professional.

Two respondents had two or more diagnosed health problems before they became homeless, significantly fewer than the 13 respondents who were aware of two or more problems. One respondent was diagnosed to be suffering from learning difficulties and migraines and the other was diagnosed to be suffering from behavioural problems, suicidal depression and sleeping problems. Data were not collected on respondents' utilisation of health care before they became homeless making it difficult to explain the discrepancy between diagnosed and self-reported health status before respondents became homeless. However, problems that respondents were aware of but had not been diagnosed as recognisable disorders by a health professional were having a significant impact on their everyday lives and role in society.

Therefore, it seems fair to conclude that this discrepancy is not a consequence of respondents reporting problems that did not exist.

Table 3. 7 The range and incidence of diagnosed health problems experienced by respondents before becoming homeless.

<u>Health problem</u>	<u>Number of respondents with diagnosed problem</u>		
	Women (n=10)	Men (n=10)	Total (n=20)
Respiratory/chronic chest problems	2	2	4
Heart problems	-	1	1
Digestive problems	1	1	2
Alcohol dependency	1	-	1
Drug abuse/dependency	-	1	1
Anxiety/stress/nervousness	1	-	1
Manic/suicidal depression	3	1	4
Learning difficulties/behavioural problems	3	3	6
Total	12	11	23
Number of respondents = 30			

The functional and social dimensions of health - the impact of health on everyday life and role in society.

Eighteen (18) respondents recalled that their health had a persistent effect on their everyday life and role in society before they became homeless. Difficulties getting out and about were the most common way that health restricted what respondents were *able* to do. Problems with friends and family and restricted job opportunities were the most common ways that health limited what respondents were *allowed* to do.

Three respondents recalled physical health problems that had a major impact on their life before they became homeless. Jo is a 20 year old woman and has been homeless six months. Before becoming homeless Jo was suffering from a severe abdominal pain that the health

service had been unable to diagnose. Jo was experiencing this severe pain at least a couple of times a month and sometimes the pain was so bad that she was unable to get up out of bed. On a number of occasions she had been admitted to hospital. Gary is 20 years old and has been homeless one year. Gary was suffering from depression and severe migraines before he became homeless. Every couple of weeks the migraines were so bad that he could not function and sometimes had to be taken into hospital. Charlie is 65 years old and has been homeless for one year. Before becoming homeless, Charlie was suffering from heart problems that effected his ability to get around, were persistent and amounted to some degree of disability. Charlie was also suffering from suicidal depression following the death of his wife and talked of not wanting to go out and not wanting to meet people:

CHARLIE -I said to hell with it and took a bottle of whiskey and half a bottle of vodka out of it and some cans of beer out of the fridge. I went and got cigarettes out of the drawer and that was me. I woke up at three in the morning on the floor and I hadna put the heating on and there was an old lady next door and I was that bad that I couldn't get a cup of tea and when I knew this old lady was in at about eight in the morning I went to her back door to ask if she could make me a cup of tea. She was going to make me breakfast but I couldna face it so she made me a piece of toast and a cup of tea and she said 'I just wondered when you were going to come in and have a talk', she said 'I have watched you come in'. I was trying to hide what I was doing and I couldn't and she said 'I am glad you came'. The minister used to come down and I could see him coming down. I knew that he was coming for me because he was a wee bit worried and I used to put the latch down on the door and away up the stairs and make that I wasna in.

PSP7

In total 11 respondents recalled how their health restricted their day to day life and caused them problems getting out and interacting with people. Chris, a 22 year old women, has been homeless three months and was suffering from depression before becoming homeless. Chris recalled that her depression, which had not been diagnosed by a health professional and for which she was not receiving treatment, was having a significant impact on her everyday life:

DR - What was wrong with your health at that time (before becoming homelessness)?

CHRIS - Well, it was the depression again, it was just, the flat was really getting me down at the time and I just couldn't take any more and I just felt so alone even though me brother was there, I just felt like there was no one there at all.....

DR - When you were living in the flat with your brother do you think that your health at that time was affecting your day to day life in anyway?

CHRIS - Yeah, I mean, I was scared to go out but then again I was scared to stay in the flat on me own. I was a nervous wreck.

CST4

Eight of the 11 respondents whose health caused them problems getting out and interacting with people related their health problems and the impact they had on their everyday life to mental and physical abuse from a partner or family member. All eight of these respondents are women. Roz is 42 years old and before she became homeless was suffering from asthma, anxiety, stress and sleeping problems and was finding it difficult to get out and do anything. Roz related these problems to the violence she had suffered from her partner who she was living with at the time:

DR - What was causing your health to be worse at that time?

ROZ - Probably just worry, I had a lot to think about with the violence. I was, if he went out I was frightened waiting on him coming in and I would just get myself up tight...I was feeling tired a lot of the time and I couldn't really be bothered and that's not like me at all.

CST1

Some of these eight respondents talked about how the impact of health on their everyday life in turn affected how they were treated by the partner or family member who was abusing them. Rachel is 17 years old and has been homeless one year. Before becoming homeless Rachel was suffering from depression and behavioural problems and was being physically abused by members of her family:

DR - When you were living with your mother down in the Borders, why did you leave there?

RACHEL - My mum was hitting me a lot. That's all a long story. My mum and her next door neighbour brainwashed me into believing that my dad had sexually abused me and my mum was like..., I was getting practically battered every day. I was getting lectures every day. I couldn't do my work at school and I failed everything.

Rachel recalled how this abuse impacted directly on her health:

DR - Was there anything wrong with your health at that time?

RACHEL - It wasn't particularly my health. It was psychologically. My mum used to put me under a lot of pressure and I just felt stressed out all the time and the teachers at school could see that there was something the matter...she was making me ill.

Rachel was taken by her mother to see a psychiatrist because of problems that were a direct consequence of the way her mother had treated her:

DR - Were you seeing any one about your health when you were living with your mother?

RACHEL - Well, my mum made me go to a psychiatrist 'cause of what had happened and they believed it. It still didn't make me feel any better. I still knew there was something wrong. Even though I went to the psychiatrist it still wasn't helping me 'cause that was what the problem was, home.

DR - Did you go see the psychiatrist regularly?

RACHEL - Oh yeah, regularly. I went to the sick kids. I used to be crazy. Everyone used to think I was crazy.

BDR3

Helen is 25 years old and has been homeless two years. Before becoming homeless she was suffering from anxiety/stress and lethargy, neither of which had been diagnosed by a health professional. Helen had also been the target of abuse and recalled how, because of the impact of threats and actual violence from her ex-partner on her health, she had lost her job:

DR - Was there anything wrong with your health that was effecting what you could do?

HELEN - I was paranoid. I couldn't relax 'cause I thought this person was going to turn up and if the door went I didn't answer it. It was just exhausting.

DR - Did your health affect your day to day life in any way?

HELEN - Yeah, well, going out. I didn't like to go out in case he was waiting...I didn't go into work. I just started vegetating.

DR - You stopped going into work?

HELEN - Aye, I couldn't go back then...I just didn't go in.

ADC2

In total, seven respondents recalled that before they became homeless their health restricted their employment opportunities. Five of these seven respondents were in receipt of invalidity or sickness benefit, three because they were suffering from manic depression, one because of a heart problem and one because of learning difficulties.

Summary.

The majority of the homeless people with health problems interviewed in this study were experiencing health problems that impacted on what they were able and allowed to do before they became homeless. The significance of this finding cannot be overstated. The fact that people with health problems are becoming homeless despite the welfare role built into the housing system is evidence that the controversial issue of health selectivity out of and into the housing system warrants attention.

3.2.2 Is homelessness hazardous to health?

The longitudinal data on respondents' health histories also reveals that 28 out of 30 respondents have experienced a change in their health - range, incidence and nature of problems - since becoming homeless, suggesting that the impact of homelessness on health also warrants attention. Eighteen (18) respondents are experiencing new problems and eight respondents' have existing problems that have got worse. These experiences support the thesis that homelessness is hazardous to health. However, 11 respondents said that pre-existing health problems have improved or disappeared altogether since they became homeless.

Comparison of respondents' health before and since becoming homeless.

Comparing the range and incidence of health problems respondents were experiencing before and have experienced since becoming homeless provides a quantitative assessment of how respondents' health has changed since becoming homeless. The most striking finding to emerge from this comparison is the number of new problems respondents have experienced since becoming homeless (Table 3.8).

Table 3.8 Number of respondents experiencing new health problems since becoming homeless

<u>Number of new problems</u>	<u>Women</u>	<u>Men</u>	<u>Total</u>
	<u>(n=13)</u>	<u>(n=17)</u>	<u>(n=30)</u>
0	6	6	12
1	4	5	9
2	2	1	3
3	1	3	4
4 or more	-	2	2

Since becoming homeless 18 respondents have experienced the onset of, often severe, mental and physical health problems that include anxiety/stress, sleeping problems, lethargy/exhaustion, respiratory problems, eating problems and musculoskeletal problems. However, not all respondents have experienced new problems since becoming homeless. Twelve (12) respondents are unaware of any new problems and seven respondents noted that one or more health problems have disappeared. Drug dependency, exhaustion/lethargy,

asthma, musculoskeletal problems, loss of consciousness and anxiety/stress are all problems that respondents recalled experiencing before becoming homeless but are no longer experiencing.

Clearly, respondents have experienced a change in health status since becoming homeless. In order to gain a deeper understanding of the nature of change, respondents were asked to qualify if and how their health has changed since becoming homeless.

Change in health since becoming homeless: the experience

Respondents were asked if their health has improved, got worse or stayed the same since they became homeless. Only two respondents said their health has stayed the same. Twelve (12) said their health has improved and 16 said their health has got worse. However, when respondents were asked about the onset of new problems and existing problems getting worse, the vast majority described how their health has deteriorated since becoming homeless.

New problems - Eighteen (18) respondents referred to new health problems that have developed since they became homeless, including severe mental and physical health problems such as respiratory and chronic chest problems, blackouts or loss of consciousness, epilepsy, problems with alcohol and drug use and manic and suicidal depression (Table 3.9). Cameron is 21 years old. Before becoming homeless he was unaware of any health problems. In the five years since he became homeless, Cameron has experienced the onset of a problem with drug use, flashbacks, lethargy, paranoia and sleeping problems. As reported in section 3.1.2, Cameron's health now has a significant impact on his everyday life and he has problems raising the motivation to do anything. New problems have often impacted on what respondents are able and allowed to do. Charlie, a 65 year old man, was suffering from suicidal depression and angina before becoming homelessness. In the nine months since becoming homeless Charlie has experienced the onset of bronchitis which has exacerbated problems he was already experiencing getting out and about:

DR - Do you think that since you left that flat in Derby through to the present that your health has got worse, improved or stayed the same?

CHARLIE -I think it has gradually got worse 'cause there are things that I used to do if I do know I am quite out of breath and get a lot of pain and I have got to sit

down or get back here and lie down and I don't try to walk far anymore because of how I am.
PSP7

Phil is 36 years old. In the 2 months since becoming homeless he has experienced the onset of sleeping problems, eating problems and anxiety/stress. When asked how his health has changed since becoming homeless, Phil talked in general terms about 'feeling worse':

DR - How has your health got worse since you left that flat and became homeless?
PHIL - I think that me state of mind gets worse with the circumstances. Put the clock back six months, you always think what you should of done. So, it's not your health but obviously it affects your health.
DR - How has your health been affected since you left that flat in London?
PHIL - Well, like I say, your state of mind and you're not getting sleep and the food you get....it's not really a problem. It doesn't worry us any. Sometimes you feel it and sometimes you don't but it's just no good really.
PSP5

Table 3.9 The range and incidence of new health problems respondents have experienced since becoming homeless.

<u>New health problem</u>	<u>Self reported health</u> <u>(n=18)</u>
Respiratory/chronic chest problems	4
Dermatological problems	1
Loss of consciousness	-
Sleeping problems	5
Genitourinary problems	2
Constant flu/colds	2
Aching joints and muscles	3
Sever headaches/migraines	2
Lethargy/exhaustion	4
Flashbacks	1
Eating problems/disorders	3
Epilepsy	1
Alcohol dependency	1
Drug abuse/dependency	2
Anxiety/stress/nervousness	7
Manic/suicidal depression	2
Total number of respondents = 30	

Existing problems have got worse - Eight respondents talked about mental and physical health problems that have got worse since they became homeless. Manic or suicidal depression, musculoskeletal conditions, anxiety or stress, digestive problems, respiratory problems, heart problems, walking problems and exhaustion are all problems that respondents are aware have got worse since they became homeless. For some respondents, the deterioration in health has been severe. Sandra is 38 years old and was suffering from anxiety/nervousness and depression before she became homeless. In the two and a half years since becoming homeless her depression has deepened and developed into manic/suicidal depression, for which she is receiving treatment. Sandra is now also suffering from exhaustion and muscle pains:

DR - Since you left that flat that you were living in with that man..., do you think your health has got worse, improved or stayed the same?

SANDRA - Worse.

DR - In what way do you think it has got worse?

SANDRA - It got worse when I couldn't do anything and I've got more depressed, mostly exhaustion and muscle pain. That's what I get mostly. I got to the stage at one point that I was rocking, you know, and that's when you feel that you're going insane, or rocking about like a zombie sort of thing.

SFD1

The deterioration in Sandra's health has impacted on her everyday life. She now has problems getting out of bed, out of her accommodation and meeting people.

Respondents also talked generally about how their whole 'well being' has deteriorated since they became homeless. Feeling 'more stressed out', 'unhealthy' and 'unfit' are all ways in which respondents described the change in their health since becoming homeless. In the six months since becoming homeless, Jo has experienced the onset of severe headaches and depression. However, the biggest change she has noticed in her health is the general feeling of 'not being well':

DR - In what way do you think your health has got worse since you left that flat?

JO - I think I feel more stressed out, I canna sleep sometimes. I just don't feel right, I really crab at everyone. I get these sore heads. I feel quite sick a lot actually. I don't why that is.

CST2

Two respondents are aware of how a deterioration in their mental health since they became homeless has impacted directly on their chance of gaining or holding on to employment. Both these respondents are now in receipt of invalidity or sickness benefit.

Improvements in health - Eleven (11) respondents are aware of an improvement in their health since becoming homeless, problems either getting better or disappearing altogether. However, all these respondents are still experiencing health problems. Nine of the 11 respondents who have experienced an improvement in health attributed this change to the improvement of mental health problems, including anxiety/stress, drug abuse/dependency, manic/suicidal depression and lethargy. Only two respondents reported an improvement in physical health since becoming homeless, one respondent experiencing an improvement in a severe case of asthma and one respondent experiencing an improvement in a problem with migraines.

Callum is 19 years old and has been homeless four months. Before becoming homeless Callum was suffering from respiratory problems, depression and a severe problem with drug use that involved him taking 'speed', 'ecstasy', valium and a range of tranquillisers on a daily basis. Since becoming homeless his level of drug use has dropped but he is still suffering from a respiratory problem, depression and struggles to find the motivation to do anything. Cathy's health has also improved since she became homeless. Cathy is 28 years old and has been homeless less than a month but in this short time her mental state has improved and her manic depression has stabilised:

DR - Since you left the flat do you think that your health has got worse, improved or stayed the same?

CATHY - I think it has improved a bit. I have been able to sleep a lot better and I have been able to get off to sleep a lot quicker and I don't have the same sort of stress and I am not uptight all the time and I'm sort of relaxed.

ADC1

However, Cathy is still suffering from manic depression and a deterioration in her condition may result in her being institutionalised. Consequently, as discussed in section 3.2.1, her health still represents a threat to her freedom, as well as affecting how people treat her. In total, 10 respondents were aware of mental health problems, including drug dependency, anxiety/stress/nervousness, manic/suicidal depression, that have improved since they became homeless.

The health histories of these 11 respondents illustrate an important point that is overlooked in the assumption that health inevitably deteriorates as a result of being homeless. The health status of each individual is the product of an ongoing process involving a unique combination of factors - socio-economic and physical environment, lifestyle, genetics/constitution and

health care. When a person becomes homeless they might be exposed to a combination of factors that result in a deterioration in health. However, it is also possible that on becoming homeless a person escapes from a factor that was impacting on their health (for example, violence from a partner or family member) and so their health could improve, if only in the short term (this point is discussed in detail in Chapter 4). However, the fact that 18 respondents have experienced new health problems and eight respondents have existing problems that have got worse since they became homeless suggests that homelessness is hazardous to health and illustrates that the impact of homelessness on health warrants analysis.

3.3 Conclusion.

The health of the 40 homeless people interviewed in this study confirms the conclusion of previous studies that homeless people experience a high incidence of mental and physical health problems. The data collected on respondents' health also suggests that previous research may have underestimated the extent of the poor health profile of homeless people by failing to appreciate health problems that have not been diagnosed as a recognisable disorder by a health professional, and ignoring the impact of health on everyday life and role in society.

Research into the health of homeless people has described the health profile of homeless people but has failed to move the investigation process on to understand its determinants. In an attempt to fill this gap I collected longitudinal data on the health histories of 30 homeless people. These data allowed me to explore the relationship in time between homelessness and health and evaluate two kinds of explanation for the poor health profile of homeless people. First, I considered whether homeless people had health problems before they became homeless and found that the majority of respondents had mental and physical health problems that impacted on what they were able and allowed to do before they became homeless. This finding raises the question I address in Chapters Five and Six - why are people with health problems becoming and remaining homeless when people with health problems and in housing need have high priority among people eligible for social housing?

Second, I considered the impact of homelessness on health by examining whether and how respondents' health has changed since becoming homeless. I found that the majority of

respondents have experienced a deterioration in health that has involved either existing problems getting worse or the onset of new problems. This finding confirms that the impact of homelessness on health warrants attention. Therefore, in Chapter Four I examine the relationship between deteriorating health and respondents' physical and servicing environments and lifestyles since becoming homeless, and also account for the health histories of respondents who have experienced an improvement in health since becoming homeless.

THE IMPACT OF HOMELESSNESS ON HEALTH.

In Chapter Three I introduced two explanations that could account for the relationship between homeless and health. First, the fact that the majority of the homeless people interviewed had health problems before they became homeless suggests that the poor health profile of homeless people is, in part, a product of health selectivity out of and into the housing system. This explanation is taken up in Chapters Five and Six. Secondly, I showed that the majority of respondents have experienced a deterioration in health since becoming homeless. This finding suggests that homelessness impacts on health. In this chapter I focus on this second explanation.

Various living conditions have been related to a range of physical and mental health problems (Smith, 1989). Many homeless people are living in inadequate and insecure accommodation where living arrangements are often unsafe and violent causing distress and worry. Bed and breakfast hostels are over crowded, hazardous and unsanitary, hostels are often overcrowded, unsanitary and foster the transmission of disease and sleeping rough is damp, cold and dangerous. It seems obvious that some of the health problems homeless people experience will stem from the hazardous conditions in which they often live (Shanks and Smith, 1992). However, it is difficult to untangle the various causal mechanisms that could account for episodes of poor health (Smith, 1989).

Health status is the product of various causal mechanisms interacting in an ongoing process and it is difficult to specify the cause of a particular episode of poor health. However, evidence exists linking living conditions and ill health. In this chapter I draw on this evidence to explore the suggestion that homelessness is hazardous to health. First, I consider the problems homeless people experience accessing and utilising health care. Health servicing is

the focus of attempts to manage the poor health profile of homeless people. In this chapter I question what impact improvements in health care will have on the health of homeless people. Second, I relate evidence regarding the impact of living conditions on health to the circumstances and situations respondents have lived in since becoming homeless and discuss the extent to which homeless environments are hazardous to health.

4.1 Health Care for Homeless People.

Policy-makers have often responded to the poor health profile of homeless people with uncoordinated, ad hoc attempts to improve health care for homeless people. These attempts are a response to evidence that the lack of a fixed address is a major constraint in accessing health care (Stearn, 1987; Fisher and Collins, 1992). What I do in this section is explore the extent to which health problems experienced by homeless people are rooted in limited access to health services. First, I review existing evidence of the problems homeless people encounter accessing and utilising health care and discuss the experiences of the 40 homeless people interviewed in this study. Second, I question what impact improvements in health care will have on the health profile of homeless people given that the major determinants of ill health are outside the health care field.

4.1.1 Accessing and utilising health care.

The Patient's Charter makes it clear that every citizen has the right to be registered with a GP (Bines, 1994). However, problems accessing a GP are the main reason why homeless people have difficulties accessing health care (Fisher and Collins, 1993). GPs are the gatekeepers of the NHS, controlling patients' access to their own time, expertise and attention and controlling access to a range of other services (Foster, 1983). While this gatekeeping role is widely recognised as necessary and legitimate, evidence suggests that homeless people are failing to gain entry to the NHS through this key entry point. Two separate studies found an overall level of GP registration among single homeless people in London of 60% and as low as 27% among people sleeping rough (Stern and Stilwell, 1989; Williams and Allen, 1989). This compares to a registration rate among London's general 'housed' population of 97% (Bone, 1984). A similar level of GP registration among single homeless people was reported on a national scale by the survey of single homeless people in England (Anderson et al., 1993).

Low levels of GP registration among homeless people reflect a disturbing level of unwillingness among GPs to accept homeless people onto their patient list because they believe fundamental problems are involved (ACHCEW/CHAR, 1980; Manchester CHC, 1980; Taylor, 1987; Stern and Stilwell, 1989; Williams and Allen, 1989; Ramsden, 1991). Assumptions about the mobility of homeless people, the difficulties of registering a person of no fixed abode and financial and administrative upheavals were all cited as reasons for not accepting homeless people onto patient lists by GPs in a study of health care for single homeless people in London (Williams and Allen, 1989). GPs also anticipated problems in providing an adequate service faced with what they perceived as the time consuming needs of homeless people, and were worried about how other patients would react to what were referred to as the 'anti-social aspects' of homeless patients.

Even when registered with a GP, homeless people are not guaranteed quality care. GPs tend to favour temporary registration for homeless patients because of misconceived assumptions and stereotypes about the time and resources homeless patients might take up and how their mobile lifestyles might make continuity of treatment impossible. Under temporary registration patients' medical records are not transferred from their last GP even when temporary registration is prolonged beyond the initial three month period (Lowry, 1989). Consequently, vital medical information may not be available to the health care provider and the patient may receive inadequate or unsuitable care (Stearn, 1986; Conway, 1988).

The problems people of no fixed address encounter accessing primary care have been blamed for the disproportionate use of hospital Accident and Emergency (A and E) departments by homeless people. Evidence suggests that homeless people are often admitted with routine and marginal problems that have become serious as a result of inadequate treatment, or with problems inappropriate to the service of A and E departments (Shanks, 1983; Miller and Lin, 1988; Victor, 1992). However, other studies report that the use of A and E departments by homeless people is occasional and for genuine reasons of injury and assault and that abuse of A and E departments only occurs on a very small scale (Manchester CHC, 1980; SHIL, 1987; Stern and Stilwell, 1989). Conflicting findings are no surprise. The use of A and E departments by homeless people is bound to vary from place to place depending on the policy of local GPs and the provision of special services for homeless people. For example, Powell (1987a) found that when a primary health care centre for homeless people was opened in

Edinburgh the use of the A and E department by homeless people fell and the 'appropriateness' of consultations rose. However, it is clear that homeless people are perceived as problem patients (Fisher and Collins, 1993) and even if their use of A and E departments is genuine, their medical needs may still be marginalised.

In response to the problems homeless people encounter accessing mainstream care and evidence of inappropriate use of A and E departments, a number of projects have been set up by health authorities and individual GPs to provide open access to primary health care for homeless people. Separate services operating outside mainstream care and special services offering a route into mainstream provision have been set up in hostels, day centres and drop in clinics and outreach teams have been set up to access 'difficult to reach' homeless people (Ramsden, 1991). 'House doctor' schemes involve the assignment of a GP to a particular hostel or lodging house where the GP holds regular surgeries. Such schemes have been set up in a number of locations including Edinburgh (Powell, 1987b) and London (Holden, 1975; Balazs, 1993). Walk-in clinics involve the provision of primary care with no specific catchment area or appointments system. Clinics have been set up in a number of cities including Oxford, Newcastle and London (Stearn, 1987; Ramsden, 1991). Salaried GP schemes involve a GP serving a patient list that is restricted to homeless people. For example, Shanks (1983) reports working with a patient list restricted to people living in hostels, sleeping rough or recently discharged from prison. Finally, mobile surgeries have been used to extend primary care to homeless people who rarely use hostels and usually sleep rough (Ramsden et al., 1989).

By offering an alternative to mainstream care, special services have secured important improvements in the provision of health care for homeless people. It is questionable, however, whether the quality of care these services provide is comparable to normal GP surgeries because of limited resources and poor facilities (Stern and Stilwell, 1991). It also appears that specialist services are unsuccessful at reintegrating their users into mainstream care (Stern and Stilwell, 1991). For example, of the 1500 homeless people interviewed in a survey of single homeless people in England, more knew of a GP they could go to if feeling unwell than were registered with a GP and made greater use of medical facilities provided specifically for homeless people than mainstream services (Bines, 1994). As well as failing to integrate homeless people into mainstream care, specialist services for homeless people run the risk of

legitimising the discrimination they are designed to eliminate by absolving local GPs of their responsibility to care for homeless people, thereby perpetuating the exclusion of homeless people from mainstream care and compounding the stereotype that homeless people have excessive and demanding health care needs (Stern and Stilwell, 1989; Williams and Allen, 1989; Baylis, 1993). Evidence also suggests that special services are failing to cater for the all of the homeless population, failing in particular young people, women and people from minority ethnic groups (Stearn, 1987).

The under-use of health care services by homeless people is primarily a problem of service delivery. However, evidence also suggests a reluctance among some homeless people to register with a GP and utilise health care services. Homeless patients are often suspicious and reluctant to consult with GPs (Ramsden, 1991). Williams and Allen (1989) found that most homeless people who were not registered with a GP, rather than having tried and failed to register, had not approached a GP at all because they expected either to be refused or to receive inferior treatment. Evidence also suggests that homeless people are reluctant to consult a GP even when registered. Stern and Stilwell (1989) found that homeless people in West Lambeth make half as many visits to their GP as the general population and Anderson et al. (1993) report that although the majority of the 1500 homeless men and women interviewed in their study were registered with a GP, less than half of those with health problems were receiving care. Fisher and Collins (1993) suggest that reluctance among homeless people to register with a GP and utilise available care is the product of a cycle of reluctance whereby the unwillingness of GPs to register people who are homeless is compounded by homeless people's expectations of refusal. This adds to a sense of powerlessness and low self esteem. The result of this cycle is that many homeless people go untreated until their health problems become serious (Fisher and Collins, 1993).

It is widely acknowledged that homeless people encounter problems accessing primary health care and because of these problems are reluctant to utilise available care. However, conspicuous by its absence in discussion of health care for single homeless people is any reference to how being homeless affects access to community care. This is a surprising omission. An argument often used to explain the prevalence of mental health problems and mental illness among homeless people is that the decline in psychiatric bed space from a peak of 148,000 in 1954 to about 45,000 in 1992 has resulted in people moving out of the wards

and onto the streets (Leff, 1993). Although the 'out of the wards and onto the streets' thesis has been disputed by evidence that the majority of mentally ill people who are homeless have not lived in a psychiatric hospital (Timms and Fry, 1992) and few former patients have become homeless following discharge from hospital (Dayson, 1993), many homeless people are suffering from mental and physical health problems that are static and amount to some degree of disability. The National Health Service and Community Care Act 1990 places a responsibility on local authority social service departments for assessing the needs of people living in the community or about to leave a long term institution and for arranging a suitable 'care package' (Conway, 1995). According to the government, community care is about enabling people to stay in their own home rather than being institutionalised and providing care that fosters independence and enables people to fulfil their potential. Implicit in this agenda is integration into rather than exclusion from society (Clapham, 1991). However, housing issues were ignored in the 1990 Act. The government has since acknowledged that adequate housing is often the key to independent living (DoE and DoH, 1992) but despite evidence that a high proportion of homeless people need substantial levels of support (Anderson et al., 1993; Randall and Brown, 1993), there is little recognition of homelessness issues in community care plans (SCSH, 1994). No care agency has a statutory duty to homeless people with health problems and people who have nowhere permanent to live are, therefore, effectively excluded from the provisions of the care in the community policy (Conway, 1995).

Summary - Evidence suggests that homeless people experience problems accessing and utilising health care. The main reason for these problems is the difficulty homeless people encounter accessing a GP, the gatekeepers on the NHS. Many homeless people are either not registered with a GP or registered on a temporary basis. The policy response has been the ad hoc provision of special services for homeless people. These services have secured important improvements in the provision of care for homeless people but provide an inferior service compared to mainstream provision. Evidence also suggests that many homeless people are not receiving the support they need.

4.1.2 Health care for homeless people: the experience of respondents.

The 40 homeless people interviewed in this study have experienced problems accessing and

utilising health care. Some have encountered problems accessing the services of a GP and most are registered on a temporary basis and receive care outside of mainstream provision. Respondents are reluctant to utilise both mainstream and special service because they expect to receive inadequate or unsuitable care and many are in need of practical and emotional support but are receiving non. However, some respondents reported that they are receiving satisfactory health care and a handful reported that they have received improved care since becoming homeless.

Entering the health service

Registering with a GP - Thirty-one (31) out of 40 respondents are currently registered with a GP in the area where they live. Only three respondents reported difficulties registering and all three have since been accepted onto a GP's patient list. Two respondents had problems registering with a GP because they were new to Edinburgh and unaware where available services are located. After a couple of weeks, these two respondents found out about local services by talking to other homeless people and registered with a GP. Homeless people interviewed in the survey of single homeless people (Anderson et al., 1993) reported similar problems when moving to a new area, registering with a GP often being a daunting experience for people unfamiliar with an area (Bines, 1994).

Ian is the only respondent who has approached a GP and experienced problems registering. Ian is 18 years old and suffers from behavioural problems, depression, a knee problem that restricts his mobility, and asthma. He is currently sleeping rough or staying on a friend's floor on cold nights. Ian experienced difficulties registering with a GP soon after becoming homeless. Subsequently, he lied about his circumstances in order to secure registration:

DR - Since you left your flat, have you been able to get all the health care that you have needed?

IAN - No.

DR - Have you had any problems registering with doctors?

IAN - Well, there is a lot of doctors who don't want to see homeless people 'cause when I phoned them I told them I was phoning on behalf of someone else and they said 'do they look homeless' and what's that to do with anything? And they said 'we don't accept people who are sleeping on the streets' but they accepted me.

DR - Why?

IAN - Well, I just gave me mate's place even though I wasn't staying there. If I had said I was of no fixed address he wouldn't of accepted me.

DR - Did they accept you permanently or temporarily?

Ian has still not told his GP about his circumstances for fear of how he will react. Without knowing about Ian's situation, the job of the GP is made all the more difficult and the effectiveness of treatment may be compromised.

Ian and the two respondents who had difficulties when new to Edinburgh are the only respondents who have encountered problems registering with a GP. This finding appears to go against evidence that homeless people encounter difficulties accessing GP services. However, it is significant that 24 respondents have not tried to register with a GP providing mainstream care. At least 15 respondents are receiving treatment from a GP at a clinic for homeless people and nine have chosen not to register with a GP. The respondents who are registered with a GP at a normal surgery have avoided difficulties registering either because they were referred by a hostel or advice centre to a GP willing to serve homeless patients or because they are still registered with the GP who was treating them before they became homeless.

The decision not to approach a GP - Eleven (11) respondents have not approached the health service for help even though they are suffering from health problems. Nine of the 11 have chosen not to register with a GP and two are only registered because it is a condition of tenancy in their current accommodation. Contrary to the findings of previous studies, expectation of refusal was not a reason for not seeking help. All 11 respondents said they knew of a surgery where they could go and receive medical help. They have not sought medical help because of a distrust of the health service, a dislike of expected methods of treatment and the belief that available care would not help.

Ten of the 11 respondents who have not approached the health service for medical help with any of their health problems gave specific reasons for not seeking help with mental health problems. Conscious of the stigma attached to mental health, some respondents preferred to deal with their problems alone. Helen is suffering from anxiety, stress and bouts of depression but has chosen not to seek medical help because she does not believe the health service can help:

DR - At the moment is there anything wrong with your health?
HELEN - Well, stress, I'm suffering stress.

DR - Have you talked to anyone about it?
 HELEN - No, not yet 'cause it's really the circumstances.
 DR - What do you think causes it?
 HELEN - Well, it's just the way I live basically.
 DR - Do you think that if you wanted to see someone you could?
 HELEN - Yeah. I could go to the doctor and have a chat but then again, it's like sleeping tablets or valium.
 DR - Is that a problem?
 HELEN - Yeah. That's not what I want 'cause, I'm not ill.
 ADC2

Respondents also reported reservations about the treatment they expect to receive. Dan is 29 years old. He has a history of drug abuse and is suffering from a number of related problems (lethargy, flashbacks, nervousness). Dan has gone a year without drugs but has not sought medical help because he is afraid that the treatment he expects to receive could jeopardise his recovery:

DR - Have you talked to a doctor about any of these problems (lethargy, flashbacks, nervousness)?
 DAN - No. I just stay away from it. 'Cause as soon as you go to a doctor they give you a psychiatrist and before you know it you will be getting different tablets and that, vallies, they are really depressing. Even the weakest, they just depress you and you want more.
 ADC9

Respondents also have reservations about receiving medical help because of previous experiences. Willie is 20 years old and suffers from scabies, anxiety and a knee problem that effects his walking. In the past Willie was institutionalised for mental health reasons. Because of this experience he does not like doctors and will not approach the health service except for dropping into a clinic to receive treatment for scabies:

DR - At the moment is there anything wrong with your health?
 WILLIE - I doona ken. I donna like going to doctors. When I was 16 I got put in the Andrew Duncan (hospital) and that was supposed to be for depression, fuck all wrong with me. That was some daft social worker got me sectioned and then when I was in there I kept thinking I was mental, you're thinking all sorts.
 DR - Did that put you off going back to the doctors?
 WILLIE - Aye. They put me down as, what do you all them, a Dot Cotton, ken when you think there is things wrong with you and there isn't, a what do you call them?
 DR - Hypochondriac?
 WILLIE - Aye.....they reckon I make it up.
 ADC7

Gill is suffering from suicidal depression and has a long standing problem with alcohol use. In the past she has received treatment for both problems but has decided not to seek further help even though she feels the problems are getting worse:

DR - What treatment did you receive (when in hospital).
GILL - Well, I wouldna take any tablets.
DR - Have you had any other help or advice off people?
GILL - I was meant to see people but I didn't go.
DR - Any reason why you didn't?
GILL - I didna want to.
DR - What about the drink, is anyone helping you with that?
GILL - I have seen people but didna go back....
DR - Do you think that it is still a problem?
GILL - Well, it's a problem but it doesna bother me.....
DR - Is there any health care that you could get to help improve your health?
GILL - Well, I don't like that kind of stuff.
DR - Why not?
GILL - I don't like doctors and hospitals. I'd rather keep away.
DR - Why?
GILL - I just would, I don't like what they do that's all...I'm no crazy.
BDG3

A distrust of the health service, often based on previous experience, an unwillingness to follow through the expected course of treatment and the belief that adequate treatment is not available have combined to make 11 respondents reluctant to seek medical help. In the cycle of reluctance outlined by Fisher and Collins (1993), reluctance among homeless people to utilise the health service is a product of the unwillingness of GP's to register homeless people. In this study, reluctance to utilise available care does not appear to be related to difficulties registering with a GP. All 11 respondents who are suffering from health problems but have not sought medical help believe that they can access care if they want to. They are reluctant to utilise care because of a distrust of the health service, compounded by the belief that available care is unsuitable or suitable care is not available. However, the reluctance of these 11 respondents to utilise available care is, in part, a problem of access because the care they are reluctant to utilise is provided by special services for homeless people, services that are themselves a response to the problems homeless people have encountered accessing mainstream care.

Summary - Few respondents have experienced problems accessing health care. However, the majority of respondents are either receiving care outside of mainstream provision or have chosen not to seek medical help. The nine respondents who are not registered with a GP have

not tried and failed to register. All nine said that they know of a surgery where they can see a GP and receive medical care but prefer not to.

The quality of health care available to homeless people.

The vast majority of respondents who have sought medical help reported that they are receiving inadequate or unsatisfactory care. This is not because of problems accessing primary care and reliance on hospital A and E departments. Only two out of 40 respondents have used an A and E department on a regular basis since becoming homeless. Charlie is 65 years old. He has been homeless one year and suffers from angina, suicidal depression and bronchitis. Charlie uses A and E departments to obtain his prescriptions:

DR - Since you have been moving around after leaving Derby, have you always been able to see a doctor and get medication when you have needed it?

CHARLIE - No. I have been very devious that way. I went in the hospital waiting room and say to the receptionist that I would like to see a doctor, I'm running out. At that time I had been on pills for this pain (bronchitis) and I was on ...(tablets).. for me heart and I used to go in there and they would let me see a doctor, they would give me it and I would tell them that I didn't want to be an in-patient. Two or three times they said that they would take me in and keep me overnight but I refused to do that but I always managed to get it.

DR - So, if you needed something did you always got to the hospital?

CHARLIE - Yeah.

DR - Why not a doctor?

CHARLIE - I didn't know.

PSP7

The one other respondent who is using A and E departments on a regular basis is also moving around and uses A and E departments to obtain prescriptions. Six other respondents have attended an A and E department in the last year. All were in need of emergency help, for example, following a road accident. The reason so few respondents have attended A and E departments on a regular basis is because they can receive medical help on a walk-in basis from a local clinic for homeless people. The clinic has a full time GP and nurse who, together with visiting health professionals, provide a range of primary and secondary health care services targeted at the needs of the local homeless population. Therefore, if unable to access mainstream care, the local homeless population do not have to resort to attending the local A and E department. The vast majority of respondents, however, reported that they are receiving inadequate or unsatisfactory care.

Michael's case highlights many of the difficulties respondents have encountered securing the care they want and need. Michael is 45 years old and has been homeless three months. Michael has been suffering from manic depression for a number of years and has attempted suicide on at least one occasion. Before becoming homeless Michael was receiving treatment from a psychiatrist and a regular prescription from his GP. This course of treatment was keeping Michael on, what he described as, an 'even keel'. Since becoming homeless and moving to Edinburgh, Michael has been registered on a temporary basis with a GP at a clinic for homeless people. His new GP has no record of his case history or previous treatment and he has not seen a psychiatrist since becoming homeless. Consequently, his carefully calculated course of treatment has been interrupted:

MICHAEL - Since I've come to Edinburgh I've seen a doctor whose simply wrote out my prescription, but from here, from this base here (day centre) I'm due to see a psychiatrist because I have a psychiatrist in Glasgow but there has been no link up since, after coming to Edinburgh. I want to try and get a link up so that I can get levels of my lithium and carbamazepine, make sure my levels are right, this hasn't been done for the last two, two and a half months.
CDC1

The disruption to Michael's course of treatment has been compounded by the quality of care he is now receiving:

DR - Do you think that the health care you are receiving is adequate?

MICHAEL - No I don't.

DR - Do you think the treatment, the help you get could be better?

MICHAEL - I think it is there but it is in a skeletal form, it is there in name but very often not in person. It's there on the surface but underneath there is very little to be found.

DR - Do you think that if your circumstances were different that your health care would be different?

MICHAEL - Yeah, I think that if I was in a reasonable house up in Morningside or something, or a flat and registered with a normal doctor that I could go to in a normal surgery there would, you know, be a difference. I think the fact that you live in the Salvation Army hostel, or any hostel here, has a distinct problem 'cause you're not going to be treated like ordinary people who live in ordinary flats and have ordinary jobs. You are immediately under suspicion. You are immediately classified as possibly a junky, a thief or a drunk and there's a stigma attached to any one who inhabits or goes anywhere near one of those places.

DR - Is that inevitably going to affect medical treatment?

MICHAEL - Oh, it's going to affect everything. The stigma just spreads itself around. You're considered a no gooder.

CDC1

Michael's experience highlights a number of factors that together explain why respondents have received inadequate or unsatisfactory care since becoming homeless. First, Michael, like the majority of respondents, is not registered with a GP on a permanent basis. Consequently, his medical records have not been transferred from his last GP and his current GP is without vital information regarding his health history and previous treatment. As a result, he could be receiving inadequate or unsuitable care. Difficulties handling patient information has proved a persistent problem in the treatment of homeless people. Possible solutions have been suggested, such as patient held medical cards, but a satisfactory answer is yet to be found. Secondly, Michael, like the majority of respondents, is receiving medical help from a special service for homeless people. Special services do not provide the same quality of care for homeless people that mainstream services provide for the housed population (Toon et al., 1987; Conway, 1988; Featherstone and Ashmore, 1988; Medical Campaign Project, 1988; Powell, 1988b). They also fail to cater for the whole homeless population (Stern, 1987). Of the 15 respondents known to be registered at a clinic for homeless people only three are under 30 and only one is a women.

As well as problems accessing primary care, respondents have also experienced problems accessing the care in the community they require. Six respondents reported that the care and support they need is not available. Two of the six are men over 60 years of age and suffer from physical health problems that amount to some degree of disability. The other four are suffering from a range of mental health problems, including learning problems and manic depression. All six respondents have access to primary care, most have a social worker and some have received help from hostel staff or friends and relatives. However, all need additional care on a day to day basis. The two respondents with physical disabilities reported that they need practical help getting out and about and respondents with mental health problems talked of needing emotional support and practical guidance. It would appear that each of these six respondents fit into one of the key client groups defined in community care plans, which typically include people with mental health problems, learning disabilities, physical disabilities, drug problems, alcohol problems, suffering from HIV/AIDS and vulnerable older people (SCSH, 1994). However, they have no idea how to access the care they need.

Harry is 50 years old and has been homeless for over ten years. Harry suffers from schizophrenia and has a history of long term institutionalisation. He is currently living in a direct access dormitory hostel. He receives regular treatment from a psychiatrist and his GP as well as support and supervision from a social worker. However, Harry feels that the constant care and support he needs is not available and reported that hospital is no longer an option and no help or support is provided in his accommodation:

DR - How long were you in the Andrew Duncan (hospital)?

HARRY - I was in for four years but that was when it was a hospital. You see hospitals now jon, all the people that has got problems they canna stay in the hospital. This is why you have got a big problem, people say that there is no homeless but there is and people with mental health problems they are the first to get the axe 'cause they canna go into community care 'cause they won't about £250 and 250 and 300 and the DHSS won't pay that.

DR - Do you think that they should of kept the hospital open?

HARRY - Well I think so.

DR - Would that of helped you?

HARRY - Well, it would of done with the cuts and everything else that happened it's not possible jon....

DR - Would nurses and doctors in the hostel help?

HARRY - Aye, it would.

DR - In what way?

HARRY - Because it would help you to get your own esteem back, your own respect and better yourself..... It would make a big difference.

DR - Do you think that you get all the help and support that you need?

HARRY - You don't get enough.

DR - You need more?

HARRY - You need more but that costs money.

CDC5

Although the majority of respondents reported that they are receiving inadequate or unsatisfactory health care, five respondents feel that the standard of care they are receiving has improved since becoming homeless. They are receiving support and counselling when previously they received none, are registered with a GP when previously they were not and have accessed specialist services, such as psychiatric care, when previously they were unable. The explanation for their experience is that before becoming homeless all five had problems accessing health care. Since becoming homeless they have been able to access care through special services for homeless people. The care provided by special services might be inferior to mainstream provision, but for these five respondents it is better than no care at all.

Utilisation of health care.

Twenty-six (26) respondents are attending health care services on a regular basis (every day, week or month). However, 17 of these 26 respondents are receiving treatment for some but not all of their health problems. These 17 respondents are all registered with a GP but have decided not to seek medical help with certain problems. Asked why they are not receiving medical help with certain problems, respondents explained that they have weighed up their need for care against the medical help they expect to receive and decided not to seek help with certain problems. Asked to explain what it is about the help they expect to receive that has made them not seek health care, respondents referred to a distrust of the health service, a dislike of expected methods of treatment and the belief that available care would not help. Problems accessing medical care were not referred to.

Fourteen (14) of these 17 respondents have decided not to seek medical help with mental health problems. Anxiety, nervousness, sleeping problems, lethargy and suicidal depression are all problems respondents are aware of but have not mentioned to their GP. Particular concerns are that the health service is not geared up to help people with mental health problems and does not provide the help they need. Carol is 27 years old and suffering from anxiety and stress, sleeping problems, dermatological problems and has previously been in counselling for behavioural problems. Carol has experienced difficulties getting the help she wants with her mental health problems. She is unhappy with the treatment she expects to receive and has decided not to seek help, except with a dermatological problem:

DR - Have you seen a doctor about these things (anxiety, sleeping problems)?

CAROL - I have been speaking to a friend, I didn't feel that I could speak to my doctor.

DR - Why not?

CAROL - They were just unapproachable...not very clued up....I think they are going to give you pills and that is going to take your problem away and it doesn't that. I think talking to one another is a good thing.

DR - Can't you talk to your doctor?

CAROL - No, I don't want to.

CST7

Respondents have also decided not to seek help because they feel they can deal with a problem themselves or because they do not believe the problem is worthy of attention. Doug is 20 years old and has been homeless one year. Doug is suffering from sleeping problems, lethargy,

migraines and learning difficulties. He is receiving medical help for migraines and assistance because of his learning difficulties but has not mentioned his sleeping problems, lethargy or anxiety to his GP because he blames these problems on his circumstances (living in a hostel) and does not see how his GP can help:

DR - You said that you talked to a doctor about your migraines, have you talked to anyone about feeling down, your problems sleeping or being tired a lot of the time?

DOUG - No.

DR - Why not?

DOUG - It's not really a problem that he could help me with, it's just being in here, I'll deal with it me self. It's not something I need a doctor for.

PSP3

Seventeen (17) respondents have not received medical help with certain problems. Together with the 11 respondents who have not received medical help with any of their health problems, this means that 28 out of 40 respondents have health problems that have not been diagnosed or treated by a health professional. This finding explains the discrepancy between the self-reported and diagnosed health profile of the 40 respondents. In Chapter Three it was revealed that respondents self-reported a wider range and higher incidence of health problems than have been diagnosed by a health professional as recognisable disorders. The fact that 28 respondents have health problems that have not been diagnosed or treated by a health professional is evidence that this discrepancy is not a product of respondents reporting problems that do not exist but a result of the difficulties respondents have experienced accessing adequate and satisfactory care.

Summary - The provision of special health care services for homeless people have ensured that respondents who want to see a GP are able. However, although few respondents have had problems accessing health care, access to satisfactory health care is a real problem. Other than the three respondents who have no problems and five respondents who reported that they are receiving an improved service since becoming homeless, all respondents are either receiving inadequate or unsatisfactory care, or expect to receive unsatisfactory care and have so decided not to utilise the health service.

4.1.3 Health and health care.

Improvements in the provision of health care have been the focus of attempts to manage the

poor health profile of homeless people. These initiatives are a response to evidence that homeless people experience problems accessing and utilising health care. As such, they are necessary and welcome. The determinants of health are, however, largely outside the health care system (McKeown, 1976). No evidence exists to suggest that inadequate or unsatisfactory health care is a sufficient cause to bring on a health problem or a necessary cause that must be present for a problem to occur. It is, therefore, questionable what impact improvements in the provision of health care will have on the health of homeless people.

No obvious relationship, correlation or common experience links the range or quality of care respondents have received to the onset of health problems. Respondents experiences do illustrate, however, that health care and social support are key resources for coping with risk factors that can impact directly on health. This point can be illustrated with the help of two case studies. Michael's case was discussed in detail earlier and provides a good example of how inadequate care might not cause, but can exacerbate existing problems. Michael is 54 years old. He has been homeless for three months and is suffering from manic depression. Before becoming homeless Michael was receiving regular treatment from a psychiatrist and GP and his condition was stable. Since becoming homeless, Michael has been treated by a GP at a clinic for homeless people and has not seen a psychiatrist. During this time his health has deteriorated. He has been living in a dormitory hostel for homeless men and has little or no privacy. He feels unsafe and insecure and has problems getting a nights sleep and adequate food. During this period he has been through periods of deep depression and has considered suicide. The lack of adequate care and support is not the cause of Michael's manic depression. Nor is it the sole reason why his health has deteriorated since he became homeless. However, continuity of care and emotional support could have limited the impact of the stress and strain of homelessness on Michael's health.

Sandra is 38 and has been homeless two and a half years. Before becoming homeless Sandra was suffering from mild depression. Since becoming homeless, Sandra's health has deteriorated dramatically. Her depression has deepened and she now experiences suicidal tendencies. She also suffers from exhaustion and aching joints and muscles. Since becoming homeless Sandra has not been able to get the care or support she wants or needs. She has approached her GP a number of times for help with depression and has tried admitting herself to hospital:

DR - Have you received any treatment?

SANDRA - Well I've just seen them now and again and I found it difficult to get treatment 'cause when I got to my worst they put me in the Andrew Duncan (hospital) for one night but they got the police to take me out of it because, what it was was that I thought that I had found help and I wanted to be in the hospital 'cause I wanted just to get better, I didn't want to think about anything else and I only saw one student psychiatrist and on that they decided that I was not to get to stay in, not to get any help at all, to go back to my doctor so I of course cracked up and started shouting and picked a chair up and threw it at the wall and that's when they got the police and they came and made me leave.....

DR - Did you go back and see your GP?

SANDRA - That's right.

DR - Your GP didn't refer you to anybody?

SANDRA - My GP just pressed a few buttons on a computer and sent me home really.

DR - That was all the help they gave you?

SANDRA - That was it really.

DR - Did your doctor give you no help at all, no prescriptions or treatment?

SANDRA - No.

SFD 1

Sandra does not attribute the dramatic deterioration in her health to the inadequate care and support she has received since becoming homeless. Rather, she blames the abuse she suffered from a former partner and the insecurity of being homeless. However, she did report that if care and support was available to help her cope with deepening depression and its impact on her everyday life, the deterioration in her health would not have been as dramatic and recovery might have been quicker:

DR - What about if you had had help and support, would that of made a difference?

SANDRA - Definitely. At one point I needed someone to visit me.

DR - Wasn't that support there?

SANDRA - No and it wouldn't of mattered if I was living in Buckingham Palace, that's how it affects you.

DR - What about the availability of health care, do you think that if you had got more help care, you GP had referred you to someone, that would of helped you?

SANDRA - It would of been easier to cope and I mighten of got so ill.

SFD1

Care and support have an important role to play in the maintenance of good health and recovery from poor health (Dean et al., 1990; Fitzpatrick et al., 1991; Oakley, 1992).

Inadequate health care is not a cause of poor health but can exacerbate existing problems. It is therefore important that homeless people have the guaranteed right to the full range of health care and support.

If inadequate or unsatisfactory health care is not a cause of ill health, it is important to ask why attempts to manage the poor health of homeless people focused on the provision of health care? To answer this question it is necessary to appreciate the scholarly context of research into the health and homeless problem and the political considerations shaping policy-making.

Studies of the health of homeless people are, by and large, epidemiological investigations. Epidemiology is the study of the distribution and determinants of states of health in a human population (Susser, 1973). The aim of epidemiological study is to understand the occurrence and development of states of health, to discover their causes and to prevent them (Susser, 1973). There are two key elements to any epidemiological investigation. Descriptive studies determine the frequency of a disease, the kind of people suffering from it and where and when it occurs (Barker and Hall, 1991). The logical next step and second key element is analysis of the determinants of disease, the factors that bring about a change in health condition (Susser, 1973). Studies of the health of homeless people have described the range and incidence of health problems among the homeless population. They have, however, failed to move the investigation process on and establish the determinants of the poor health profile of homeless people. Policy-makers have, therefore, been provided with descriptive data valuable for the planning of health care delivery but have not been advised about the risk factors responsible for the health profile of homeless people. As a result, the only informed response to the health of homeless people which policy has been capable of is securing improvements in health care provision.

The failure of research to provide an insight into determinants of the health profile of homeless people and the focus of attention on health care provision has proved politically convenient. Attention has been diverted away from other policy areas that should be addressing the health of homeless people (Shanks and Smith, 1992). Understanding the determinants of the health profile of homeless people involves looking beyond the health care field and recognising that increasing numbers of people are becoming homeless and being exposed to harsh living conditions and hazardous lifestyles. Understanding the recent dramatic rise in homelessness involves appreciating the role of housing policy in restructuring housing provision away from subsidised renting and toward subsidised home ownership, and asking what are the social implications of the pursuit of a 'property owning democracy'? This is an unappealing option for the government. To question the social cost of restructuring housing provision is to

question the wisdom of the New Right ideal of rolling back the state and freeing the market, the ideological driving force behind welfare policy over the last 16 years. However, the government has been fortunate. Research has failed to move on from describing the health profile of homeless people and to understand its determinants. Concern has focused on health care provision and attention has been diverted away from politically sensitive questions regarding the significance of housing provision to the health profile of homeless people.

The experiences of the 40 homeless people interviewed in this study confirm that homeless people encounter difficulties accessing and utilising health care. No evidence exists to suggest that health care is a significant determinant of poor health and there is no relationship between the onset of ill health and the health care respondents have or have not received. However, their experiences do confirm that care and support are important resources for coping with risk factors that impact directly on health. Health care is not a significant determinant of the poor health profile of the 40 respondents but is a contributing factor. This conclusion leaves unanswered a key question - what risk factors are responsible for the deterioration in health that the majority of respondents have experienced since becoming homeless, and what factors could account for some respondents experiencing an improvement in health? This question is the focus of the remainder of this chapter.

4.2 The Health Consequences of Being Homeless.

It is difficult to account for the causal factors responsible for episodes of poor health. The prevailing medical and political dictum is that the major causes of mortality and morbidity in contemporary British society are the product of lifestyle choices. The behavioural explanation of illness causation fits comfortably into this ideology and is expounded in official documents (Nettleton, 1995). Behavioural or cultural explanations focus on the ways that different social classes live. It is assumed that lifestyles vary between people in different social positions and that lower social classes indulge in more unhealthy behaviour. Recently, however, there has been a revival of interest in the environmental determinants of ill health. Structural or materialist explanations focus on the socio-economic circumstances in which people live. Social inequalities in health are related to factors such as poverty, unemployment, income and housing conditions. Behaviour and lifestyle are recognised as contributory factors but mediated by social and economic circumstance. This revival of interest in the socio-economic

determinants of ill health is largely the result of evidence that social inequalities in health are widening and poor health is closely associated with material deprivation.

Within British society there are inequalities in health, even though the political label for these is now 'variations'. Higher rates of morbidity and mortality have been recorded amongst disadvantaged men and women. Most of the killer diseases effect the poorest occupational classes (both men and women) more than the rich (Black et al., 1982; Blane, 1991). At every stage of life, from birth to old age, the risk of death is much higher for the lowest occupational groups than among the highest occupational groups and the difference in death rates between classes have widened in recent decades (Whitehead, 1988; Davey Smith et al. 1990; Townsend, 1990). Lower occupational classes also experience more health problems during their lifetime (White et al., 1993). Differences are most pronounced in middle age when health deteriorates more rapidly among people who are socially disadvantaged (Blaxter, 1988). The unemployed population have poorer health than people in work. Cross-sectional studies, such as the General Household Survey, have consistently reported that unemployed men and women are more likely to report health problems than people who are employed (Nettleson, 1995). Death rates are also higher among unemployed people (Whitehead, 1988), even accounting for health selection into unemployment (Moser et al., 1987). Persistent differences have also been found in mortality and morbidity levels among both men and women living in three different housing tenures - owner occupied, private rented and local authority housing - although variations do exist within each tenure type and little account has been made of the effect of health selection into and out of tenures. The lowest morbidity and mortality levels have been recorded among people living in owner occupied housing and the highest levels among people living in local authority housing (Goldblatt, 1990a; 1990b). Many homeless people are socially disadvantaged, unemployed and living on low incomes. It is not, therefore, surprising that homeless people are experiencing a high incidence of a range of mental and physical health problems. Homeless people, however, have the added disadvantage of exposure to extreme living environments.

In their influential report on the nations health, Black et al. (1982) conclude that the most significant role in reducing inequalities in health can be played by measures to reduce differences in the material standard of living. This view has been legitimised by a growing body of evidence relating health status to living conditions. In particular, evidence has

emerged that the large amount of system built dwellings constructed from the 1950s through to the early 1970s are showing physical problems that are having a persistent and serious effect on the health of their residents (Conway, 1995). In the remainder of this Chapter I relate this growing body of evidence linking living conditions and health status to the circumstances and situations respondents have lived in since becoming homeless and discuss the possibility that homeless environments are a precursor of poor health and a constraint on healthy behaviour.

4.2.1 Associations between homelessness and deteriorating health.

Since becoming homeless the majority of respondents have experienced a deterioration in health. Being homeless often involves living in overcrowded, unhygienic accommodation that lacks basic facilities and is unsafe, insecure, lacks privacy and restricts freedom. Studies of the health effects of housing conditions have repeatedly concluded that the location, fabric and conditions of living environments impact on mental and physical health (Smith, 1989). For example, dwelling construction has been related to household accidents, poor facilities such as faulty gas cookers and paraffin heaters have been related to respiratory problems, living density effects hygiene and can increase risks of infectious diseases, overcrowding is associated with mental illness and a catalogue of evidence links damp and cold with incidence of disease. In light of evidence linking housing conditions and health, it seems obvious that some of the health problems experienced by homeless people will stem from the conditions in which they live (Shanks and Smith, 1992).

Since becoming homeless, respondents have lived in a range of situations - temporary supported accommodation, short and long stay hostels, lodging houses, bed and breakfast accommodation, sharing with friends and relatives, squatting and sleeping rough. However, respondents reported many shared experiences when asked to recall the physical and social environments they have lived in. Michael's case highlights many of these common experiences and is worth recounting in detail. Michael has been living in a dormitory hostel for homeless men since becoming homeless three months ago. Michael reported that the hostel is cramped and overcrowded and lacks adequate facilities. The lack of space means little or no privacy and enforced social interaction. Rules and regulations restrict freedom and Michael reported

feeling threatened by other residents. However, he is unable to move out into alternative accommodation because of the financial upheaval and insecurity moving would involve:

DR - To start with I'd like to talk about where you are living at the moment. What accommodation are you living in at the moment?

MICHAEL - I'm living probably in the greatest hell hole in Edinburgh, which is the X hostel. A large dormitory with forty to fifty people in it. Beds with about two inches between each other, lockers that cannot be locked, meals that are inedible, it's kind of horrifying really.

DR - So what do you think of the physical conditions?

MICHAEL - Lousy, in fact it should be condemned.

DR - What about facilities, like washing facilities and such like?

MICHAEL - Well there are some things that work but there are never any soap or towels, you've got bring that in yourself.

DR - Do you share facilities with other people, or do you have your own?

MICHAEL - Oh no, no, there's just one large room that we all sleep in, and there's one large lounge that has television playing all the time and I like peace and quiet and I've nowhere to go for peace and quiet in the entire building except sitting on the loo which is not conducive to producing anything worthwhile

DR - Are you happy in the hostel?

MICHAEL - Yeah, I'm totally unhappy there but because I've got everything organised with the DSS, and the Housing Benefit I feel afraid to move. It's all organised. Everything has come through, everything has been organised financially that to move at all causes a difficulty, cause there's a hold up somewhere and this can leave you with periods of nothing at all in your pocket. You see my point, you're kind of trapped.

DR - You say that you are sharing these facilities with lots of other people, how do you get on with these other people?

MICHAEL - They have learnt to leave me alone, I'm left alone.

DR - Do you get the privacy that you need?

MICHAEL - No because obviously when they get very drunk or high on drugs.....they're liable....I feel more of a social worker myself because they come and talk to me and tell me their stories, their life stories from beginning to end....no it's just a horrifying existence. The language is profound, profoundly bad and I think the conditions cause a lot of the difficulties they have because if the conditioned were better people would be better.

DR - What about your freedom, are there any restrictions on when you can come and go?

MICHAEL - There is an eleven o'clock curfew at night and it's very difficult to get out early in the morning. I'm sort of an ambulist from five to eight in the morning and if I want a cigarette at five in the morning the door is locked. I'm sure it's against fire regulations, having a padlock on the door as well as lock, but it's nothing to do with me.

DR - What about safety in there, do you feel safe?

MICHAEL - If someone wants to put a knife in your back someone will put a knife in your back, there's no safety at all.

CDC1

The experience of being homeless as recounted by respondents is not identical. There is variation in the type of accommodation and conditions in which respondents have lived. However, the common experience is of hazardous physical and social environments. The vast

majority of respondents reported that since becoming homeless they have lived in environments that restrict their individual freedom, are unsafe, insecure and lack privacy. Most have lived in inadequate and hazardous physical circumstances in which cooking, toilet and bathroom facilities are inadequate, unsafe, dirty or absent all together and living space is cramped and over crowded. Consequently, some respondents have been forced to adopt certain forms of behaviour. Poor eating habits have often proved unavoidable, exposure to a culture of drink and drug dependency is common, financial problems are a part of life and the stigma and social exclusion attached to being homeless is ever present. For respondents living on the street, many of these problems are taken to an extreme - how to get a wash and keep clean, how to eat a cheap and healthy diet, how to keep warm, dry and safe and get a good nights sleep? Given available evidence of the impact of living conditions on health, it seems reasonable to suggest that these experiences could impact on physical and mental health.

Shared accommodation and overcrowding.

All respondents have lived in cramped or overcrowded accommodation since becoming homeless. All 40 have shared toilet and bathroom facilities and 35 have shared sleeping accommodation with another person. Twenty-two (22) respondents have lived in dormitory accommodation sharing facilities with up to 50 other people. Overcrowding puts pressure on facilities that may already be unsafe and unhygienic. Respondents have had to contend with dirty and unhygienic living conditions and inadequate and unsanitary toilet and bathroom facilities. Three respondents reported that the state of repair, cleanliness and accessibility of facilities in their current accommodation is so bad that they refuse to use them. Instead they shower and wash at a local day centre or health clinic where clean facilities are available.

Evidence suggests that internal density or the degree of crowding in accommodation can have a significant impact on physical health. Overcrowding - too many people per room - affects hygiene and sanitation and increases the risk of infectious disease (Hunt et al., 1986; Smith, 1989). The risk of transmission of infectious disease and death rates for particular non-infectious diseases are highly correlated with levels of crowding (SCOPH, 1994). For example, dormitory hostels have long been recognised as reservoirs of pulmonary tuberculosis infection (Patel, 1985). Evidence also links overcrowding to the incidence of respiratory diseases. Kellet (1989) recorded a high correlation between bronchitis, asthma, emphysema

and overcrowding, even accounting for social deprivation and smoking. On this evidence, it is reasonable to conclude that the overcrowded and cramped conditions that the majority of respondents have lived in since becoming homeless could impact on physical health. These risks are increased by the fact that respondents reported that they spend long periods of time in their accommodation. Hygiene was also a problem reported by respondents who have slept rough. Although some day centres and health clinics provide bathroom and toilet facilities, at night respondents have had to rely on public conveniences for their personal hygiene needs and six of the seven respondents who have slept rough referred to problems maintaining the levels of personal hygiene they would like.

Evidence suggests that living in overcrowded accommodation can also have a significant impact on mental health. All respondents reported difficulties living in close proximity on a day to day basis with other people who are often complete strangers. Limited personal space and enforced social interaction has exposed respondents to situations which they would rather avoid - behaviour which is annoying, offensive and intimidating and cultures that are unfamiliar, alienating and often dangerous. Andy's experience of living in a dormitory hostel is an extreme example but highlights many of the difficulties respondents have experienced living in shared accommodation. Andy is 34 years old and has been homeless one and a half years. For four months he lived in a dormitory hostel where he was sharing facilities with up to 50 other men. He had little privacy and was forced to interact with people he would rather have avoided:

DR - What were conditions like in the hostel?

ANDY - If you can imagine, when you first go in you get put into a dorm that, the stench is really bad which I couldn't live in so for my first 3 months there I actually slept in the TV room. I refused to sleep in the dorm for that reason amongst other reasons and then they offered me a place upstairs which is another dorm and if you can imagine an accident and emergency unit, all it is a cubicle with a curtain and that's all the privacy you have. There were 16, 18 beds. There were people shouting in there sleep, a guy next door was a schizophrenic, I had to sleep with one eye open. It was a harrowing experience.

DR - How did you find it, living in there?

ANDY - I found it very difficult because in there you are subjected to, a lot of people in there have got alcoholic problems, drug related problems as well as mental health problems and to go into an environment like that when you are not used to it is quite difficult.

DR - Did you get on OK with the other people who lived there?

ANDY - Well, people like that you had to get along with them because you were living with them. You didn't necessarily have to converse with them but there was other people in there who had been in there for 15, 18 year in the same environment and who were more or less institutionalised so it was unusual day to day. There was

one particular gentleman who would walk the corridor all day. I actually reminded me of One Flew Over the Cuckoo's Nest, that sort of thing 'cause there was people in there with mental problems and I find it very hard to believe how people like myself and other people that were in there were mixed with the sort of people who were there 'cause it is very easy when you are homeless to go down that wrong road and it's much harder to stand back and to keep at it and to try and get yourself another house, try get yourself a job. So I think in all honesty I think it would be a great thing, not if they were to categorise, but be a bit more selective.

ADC 3

Only three respondents reported that they have been able to get the privacy they need since becoming homeless. The vast majority of respondents reported that sharing sleeping accommodation, living space, toilet, bathroom and cooking facilities with noisy and intrusive co-residents and staff has made it impossible for them to find peace, quiet and space to do their own thing. Crowded conditions in shared accommodation inevitably limit control over personal space and introduce the problem of enforced social interaction (Smith, 1989). Evidence suggests that difficulties controlling social interaction has consequences for psychological health as the continual presence of others causes mental strain (SCOPH, 1994; Stokols, 1976). Gabe and Williams (1986; 1993), in a study of women, crowding and mental health, found a significant relationship between crowding in accommodation and psychological distress, even controlling for socio-demographic variables. Just how stressful high density accommodation will be depends on a number of factors including the amount of time residents spend in or around their accommodation and the living conditions (Birtchell et al., 1988; Ineichen, 1993). Respondents who have stayed in hostels, lodging houses and supported accommodation often reported spending long periods of time in accommodation where living conditions are unattractive, dirty and unsanitary.

The level of stress associated with living in shared accommodation also depends on who a person is sharing with (Ineichen, 1993). Asked about the people they have lived with since becoming homeless, all respondents recounted sharing with people they find abusive, noisy, annoying, messy or difficult to get on with. A common complaint raised by younger respondents is the difficulty of living with older people. Jo is 20 years old and has been homeless six months. Jo was previously living in a hostel for young people but recently moved into a hostel for homeless women where she feels lonely and is having problems mixing with other residents:

DR - Are you happy living here?

JO - I'm no particularly happy living here 'cause I want to be with younger people. If I am going to be in a hostel I would rather be with people my own age, if you know what I mean. I was there the other night (hostel for young people). I would rather be there.

DR - Why?

JO - It's young people.

DR - Do you get on with the people here?

JO - I don't really know them but as far as I know, they talk to me enough, they talk to me enough but I want to be with people my age and that's causing problems for me. I feel enclosed here. I feel claustrophobic 'cause I canna really go out and I do I have nowhere to go.

DR - And if you were living in a place with people your own age?

JO - I could go places with them and do things with them....I'm usually alright for mixing but this time it's different, and I feel alone.

CST2

The vast majority of respondents reported that they have been exposed to a culture of alcohol and drug use since becoming homeless and at least two respondents have experienced the onset of a problem with drug or alcohol use. Cameron is 21 years old and has been homeless five years. On leaving the parental home he moved in with friends where he was exposed to a culture of drug use:

CAMERON - Well, when I moved up to town I couldn't really say no, they were everywhere and my friend and his mates were doing 'em and I couldn't really say no and I started.

Cameron's use of drugs was subsequently reinforced as he moved in and out of hostels and friends flats where a strong drug culture existed:

CAMERON - If you moved into accommodation that was shared with people and they were on the same as you, like drugs and that, then you knew that your body was going to get abused whenever you had the chance and the time. BDG 2

Respondents also reported that people who regularly use drugs and alcohol can be difficult to live with because of their unpredictable behaviour when under the influence.

Dietary patterns

The importance of nutrition to health and well-being has been well known for some time (Conway, 1991). Poor nutrition places people at greater risk of infections, in particular of the respiratory tract, and can increase the incidence of dental problems (Balazs, 1993). What foods can be eaten is determined, in part, by storage facilities, space to prepare food and

access to cooking facilities, as well as money to buy food. Thirty (30) respondents reported problems accessing food preparation facilities at sometime since becoming homeless and 21 respondents currently have no access to cooking facilities. This problem is particularly acute when sleeping rough. Living on the street makes a regular and balanced diet difficult. The seven respondents who have slept rough reported that without access to cooking facilities, they are reliant on take aways, if they have the money, and the generosity of individuals and charities providing free or cheap food through soup runs and recognised distribution points. Most of the seven are aware of various locations where cheap or free food is available. However, all reported that a stable and healthy diet is an impossibility.

Problems maintaining a balanced and healthy diet were also reported by respondents living in hostel and bed and breakfast accommodation. Twenty-four (24) respondents have stayed in a hostel or bed and breakfast hotel where they have limited space for storing food and restricted access to cooking facilities. Five of the six respondents who have stayed in bed and breakfast accommodation reported that they had to share limited food storage and cooking facilities with a number of people and consequently had problems preparing and cooking food. Respondents who have stayed in hostel accommodation reported having to contend with rules and regulations about when they can cook. Certain hostels only allow residents access to cooking facilities during set times. Two respondents reported that the regime in their current accommodation does not fit their daily routine and they are often unable to access cooking facilities when they want to eat. Some hostels also enforce rules of access that further limit use of cooking facilities. For example, one respondent reported that he is often refused access to the hostel kitchen by staff because they think he is drunk.

Some hostels and bed and breakfast hotels have no cooking facilities. Hostels with no cooking facilities for residents often provide set meals paid for by deductions from residents' social security benefit at source. Consequently, residents have little control over what is served but cannot afford to eat elsewhere. Phil has been eating little or nothing since he moved into a hostel two months ago that provides set meals:

PHIL - I have watched some people and they absolutely scoff every bit and go off for more but it is obviously what they have been used to. I have always been used to getting what I wanted or what I prefer. I have been a picky eater. Everyone here, they eat it all but I haven't looked at a thing. It depends what you have had before. May be some people are a lot better eaters. I have never been a very good eater. Some people are very, very good eaters, some people are not.

DR - Is there any where that you can go and get food if you need to?

PHIL - Oh, I just go and get chips and things if I've got money. I eat when I fancy eating. I don't like the idea where you sit down from six till seven. I am up for breakfast but I only have corn flakes 'cause corn flakes are easy to eat. I like things that are easy to eat.

PSP5

The problems respondents have experienced storing food and accessing cooking facilities have caused difficulties ensuring regular meals and a healthy balanced diet. These findings concur with evidence regarding the poor quality and quantity of the diets of young homeless people in Edinburgh (Bridges Project, 1990; Kirk et al., 1991). Although the health implications of chaotic dietary patterns are difficult to trace, Kirk et al. (1991) suggest that poor diet in young homeless people might lead to reduced ability to fight off infection and Gard and Freeman (1991) suggest that higher than expected levels of eating disorders among homeless people are related to poor eating behaviour that is often unavoidable and difficult to break. Although further research is urgently needed in this field, it seems reasonable to conclude that the problems respondents have experienced securing a balanced diet could impact on health.

Damp and cold

Damp and cold are important causes of morbidity and mortality. Damp environments have been shown to increase the incidence and severity of respiratory problems (Martin and Platt, 1987) and cold increases the risk of cardiovascular disease (Bull and Morton, 1978). Cold and damp are ever present health risks associated with sleeping rough. As one respondent said, 'no number of blankets can keep out the wet and cold winter nights when you're sleeping on the street'. There is a catalogue of evidence linking disease with damp and cold (Smith, 1989). Although attention has focused on damp and cold dwellings, the health implications of living in cold temperatures suggest an association between rooflessness and ill health. About 40,000 more people die in Britain in winter than in summer (Arblaster and Hawtin, 1993). The majority of excess winter deaths occur through coronary and cerebral thrombosis and respiratory disease - conditions precipitated by cold living conditions (Smith, 1989). It has been suggested that the mean living temperature required for comfort when awake is 21 degrees Celsius. Respiratory impairment increases if the temperature drops below 16 degrees Celsius, cardiovascular strain occurs below 12 degrees Celsius and risk of hypothermia increases as temperatures fall below six degrees Celsius (Collins, 1993). During an average winter in Edinburgh, people who are roofless are exposed to night time temperatures

commonly below freezing and day time temperatures rarely above 10 degrees Celsius. Seven respondents have slept rough since becoming homeless and during this period they all experienced a deterioration in their health and the onset of new problems, including bronchitis, asthma, recurring flu and colds, aching joints and muscles, chest problems and blackouts. It seems reasonable to suggest that some of these problems might be related to cold and damp of sleeping rough.

Insecurity.

Respondents reported that insecurity has been ever present in their lives since they became homeless. Insecurity fosters stress and stress can precipitate psychiatric disorder and physical disease (Smith, 1989). The reasons given by respondents for feeling insecure include the fear of violence, harassment and theft, limited control over their lives and social exclusion.

Many respondents are fearful of violence. Andy reported that he did not feel safe because of the behaviour of fellow residents in hostel accommodation:

DR - Was it a safe place to live, did you feel safe living there?

ANDY - No, yeah I felt safe because I am physically quite big but I didn't feel safe 'cause I didn't know what the next person was doing, he had either had too much to drink or like I say there was some people who had drug related problems and there was people who would throw tantrums in the dining room for no apparent reason so no I didn't feel 100% safe, no.

ADC3

Mistrust of fellow residents was common among respondents who have lived in shared accommodation. This is hardly surprising considering that all respondents have shared accommodation with people who they do not know and have witnessed unpredictable and intimidating behaviour, attacks on fellow residents and have themselves been the victims of assault. Nine respondents reported that they have been assaulted, two by fellow residents in a hostel, one by a fellow resident in supported accommodation and six while sleeping rough.

Dan was the victim of theft, harassment and violence when living in a hostel:

DR - Were you happy living there (hostel)?

DAN - Not at first?

DR - Why not?

DAN - Well, a few smack heads, heroin addicts. I ended up getting half my supplies stolen the first week I was there. It took a bit of time to get to know people. It's like my first time in Edinburgh so I tended to stay clear of every one.

DR - Was it a safe place to live, did you feel safe living there?

DAN - Not at first, after that I did.

DR - Why did you not at first?

DAN - Well, there was a few guys threatening and starting on me at first but it was okay if I was to fight back. If I got caught I could of got thrown out and they would of taken you for a coward but when you challenged them they wouldna come outside with you.

ADC9

Fear of harassment and violence is particularly acute among the seven respondents who have slept rough. All seven reported that they were ever fearful of harassment and violence when sleeping rough because they could be attacked at any time. Their experiences suggest this fear is well founded. Mick is 51 years old and has been sleeping rough for a number of years. Recently, Mick was violently assaulted by a gang of youths while begging on a busy city street in broad daylight. He has no idea why he was attacked. Annie was assaulted in similar circumstances. In an attempt to limit the threat of violence she has since paid a friend protection money every week. Other respondents have adopted different strategies for dealing with the threat of violence when sleeping rough. Some sleep in groups hoping for safety in numbers. Tony, on the other hand, prefers to sleep on his own. Tony is 41 years old and has been homeless over 10 years. He has been roofless for four years and has found solitude the best way to avoid trouble:

TONY - When I'm skippering (sleeping rough), no matter where I been I have always been on me own, basically 'cause I don't trust anybody. They might do me in while I am asleep and I don't want that.... I don't feel safe anywhere, obviously, if you are skippering. It's obvious you don't 'cause it might not be the other people you are skippering with but it could be the drunks or whatever. You get what I mean? Why do you think I don't tell anyone where I'm skippering?

CDC4

All respondents reported that living in temporary accommodation has limited the control they have over their life because of rules that restrict entry to accommodation and define what residents can and cannot do. Rules can be well established, although not always clearly stated (for example, in hostel accommodation), or left to the whim of an individual (for example, when staying with friends or relatives). Either way, they restrict residents control over their own life and inevitably foster insecurity.

Six respondents have been refused entry to their accommodation on an evening and forced to sleep on the street for the night. Two of the six were refused entry because they broke a night-time curfew at a bed and breakfast hotel. Night-time curfews restrict access to accommodation after a specific time and are common in direct access hostels and bed and breakfast accommodation. Some bed and breakfast hotels and hostels also enforce day time curfews that require residents to vacate the premises between certain hours regardless of the weather, their health or other extenuating circumstances. Curfews are enforced by accommodation providers, struggling with low staffing levels and high demand for accommodation and support, in an attempt to maintain control. However, they inevitably limit independence and restrict freedom. Callum is 19 years old and has been homeless four months. For two months he lived in bed and breakfast accommodation where a whole range of curfews were enforced:

DR - Where were you staying?

CALLUM - In B and B.

DR - What kind of place was it?

CALLUM - Just basically you had your own room. You had to be in for 11 o'clock during the week. You weren't allowed in the TV room 'til after five. You weren't allowed in the building between nine and five.

DR - Were there any other restrictions or rules?

CALLUM - You had to be in for 11. You weren't allowed in the building between nine and five. You weren't allowed to wander from your room after 12 and you weren't allowed phone calls after 10 o'clock.

BDG1

Having to be out of his accommodation between nine and five and having nowhere else to go, Callum spent his days wandering the streets. He recalled that during this time his asthma got worse and he often felt stressed and worried.

Rules regarding the use of alcohol and drugs have had a particular impact on the lives of a number of respondents. All respondents reported that the bed and breakfast accommodation, hostels and supported accommodation they have stayed in refuse access to anyone considered to be under the influence of alcohol or drugs and will evict anyone caught using alcohol or drugs on the premises. Consequently, fear of eviction and insecurity are ever present for people who have problems with alcohol and drug use. Four respondents have been refused entry to their accommodation because they were drunk and five respondents reported that they have been evicted from temporary accommodation for drug or alcohol use on the premises.

In total, nine respondents reported that they have been evicted from temporary accommodation. Other reasons for eviction include violence, failure to organise payment of rent and repeated failure to respect night time curfews. A further 10 respondents reported that they have had to leave temporary accommodation even though they had not broken any rules. This was because the hostel or bed and breakfast hotel in which they were staying operated a short term tenancy of two or three months after which residents must move out. Short term tenancies are common practice in temporary accommodation. Exceptions are sometimes made but only if a resident is likely to secure alternative accommodation in the near future.

A further cause of insecurity reported by respondents is the stigma and social exclusion that comes with being homeless in contemporary Britain. Inaccurate and misrepresentative generalisations have informed society's opinions and attitudes about homeless people. Homeless people have been criminalised, medicalised, marginalised and stigmatised as dysfunctional and deviant. Consequently, homelessness excludes people from opportunities open to the housed population. This fact is evident in respondents attempts to secure employment. John is 33 years old and has been homeless five years. John reported that he has been searching for employment for a number of years and has been unable to secure a job as a result of discrimination because he is homeless:

JOHN - ...I shouldn't really be grumbling that way. It is just the fact of being homeless. All the prejudices that you meet when you go somewhere. People think that you are either an alci, a drop out or a dosser. They don't realise that it could happen to anybody. They don't realise that. They just think 'he must be a smack head or a piss head' and they don't think that there is a reason behind it. You don't fit in and it's hard. They probably have never stepped foot out apart from holidays. Like now I have come back, 33 and I am trying to get back into civilisation but it is like cause I have not been born into it cause I have stepped out of it it is so hard to get back into it but I try. Also I apply for night jobs, for bar work but they don't want to know when you're homeless.....
PSP2

Homelessness has also limited respondents' employment opportunities in other, less obvious, ways. The cost of living in hostels, temporary accommodation and supported accommodation is high. If unemployed or unable to work, residents' lodging costs are met by Housing Benefit payments and the cost of board is taken from residents' social security benefit at source. However, this system of board and lodging payments is not operated in tandem with fair rent legislation. Consequently, providers of temporary accommodation can raise board and lodging costs safe in the knowledge that the welfare state will guarantee payment. In some cases, the

cost of board and lodging is so high that residents can not afford to get a job. Sandra is 38 years old and has been homeless two and a half years. Since becoming homeless she has lived in emergency council accommodation where the rent is so high that she can not afford to work:

SANDRA - If you were working then you had to pay for it and they are charging £28.50 a day.

DR - For the accommodation?

SANDRA - For the accommodation, this is homeless accommodation. So obviously, you can't work 'cause you can't afford the rent or if you could you'd be living somewhere nicer.

SFD1

As well as cutting respondents off from employment opportunities, homelessness has cut some respondents off from friends and associates. Chris is 22 years old and has been homeless three months. Since becoming homeless Chris has lived in a hostel for homeless women. She reported that since she moved into the hostel friends seemed to have cut her off and her social life has fallen quiet. Few people come to visit and she rarely goes out. Her only explanation is that the hostel must put friends off:

CHRIS - I don't see as many of my old friends now. I don't know, I think this place puts them off. You say you are staying in a hostel and they think oh god and they just tend to stay away. I used to go out and have friends round but that doesn't seem to happen no more.

CST4

Andy is 34 and is currently living in hostel accommodation. He deals with the stigma attached to homelessness by keeping his circumstances secret. However, this makes the formation and maintenance of friendships difficult:

ANDY - Not having my own house, not having a job, not having the money to eat the way I ate before, I am not as sociable as I was before for two reasons, financially and where I stay. I don't like to let people know me too much 'cause it's always the question that comes up in conversation, where do you stay? Not that I feel embarrassed about ...(the hostel)..., it's a beautiful building but it's not home. I keep it quiet.

ADC3

Many respondents commented directly and indirectly about the stigma associated with homelessness and how they have been cut off from friends and associates. This is an important finding because the support and help that friends can provide is a key resource for dealing

with stress and limiting susceptibility to ill health. Without social support, the maintenance of good health and recovery from ill health is likely to be more difficult (Dean et al., 1990; Fitzpatrick et al., 1991; Oakley, 1992).

The factors precipitating a range of mental health problems and illnesses are poorly understood but appear to include stressful life events and adverse social environments (Smith, 1989). Respondents reported that they live in fear of assault, harassment and theft, have limited control over their everyday life and have experienced social exclusion because of the stigma attached to being homeless. It seems reasonable to suggest that the insecurity and stress that these experiences foster could precipitate a deterioration in health.

Summary

Some respondents have lived with friends and relatives in spacious accommodation, or in purpose built hostels that provide adequate space and good facilities. However, the majority of respondents have had to live without personal freedom, space or privacy and have been exposed to inadequate or unhygienic facilities, violence and health threatening lifestyles. The biomedical processes responsible for episodes of poor health are difficult to unravel but in the light of a growing literature linking poor housing conditions with poor health, it seems reasonable to suggest that some of the health problems experienced by respondents will stem from living in these conditions.

4.2.2 Associations between homelessness and improvements in health.

The majority of respondents have experienced a deterioration in health since becoming homeless. However, 11 respondents reported an improvement in health, problems including lethargy, anxiety, sleeping problems and depression improving or disappearing all together. Cross-examination of these respondents health and accommodation histories reveals a relationship between improvements in health and improvements in social environment.

Eight respondents were experiencing harassment, threats and actual violence from people they were living with before becoming homeless (partners, ex-partner and family members). All eight were suffering from health problems and disabilities, including asthma, dermatological

problems, exhaustion, lethargy, anxiety, suicidal and manic depression and learning difficulties. Forced to leave their home because of violence and harassment, five of the eight moved into hostel accommodation, two moved into emergency council accommodation for women escaping violence and one moved in with relations. All eight respondents reported that their new physical environment was worse than at home and their new social environment was noisy, lacked privacy and felt insecure. However, they reported experiencing an improvement in health after becoming homeless. Respondents with sleeping problems could sleep, respondents suffering from lethargy and exhaustion started to get out and about and one respondent reported that her manic depression came under control for the first time in months. The key to the improvement in their health is that they escaped harassment and violence, a source of stress and worry they were encountering on an everyday basis and was having a significant toll on their mental health. It is worth noting, however, that five of these eight respondents have experienced the onset of new health problems since becoming homeless.

The three other respondents who have experienced an improvement in health since becoming homeless also left behind a source of ill health when they became homeless. Before becoming homeless they were involved in the drug scene in their local neighbourhood and were suffering from a problem with drug use and related ailments such as flashbacks, paranoia and depression. When they became homeless all three moved out of the neighbourhood and cut their links with drug suppliers and local users. All three reported that they wanted to limit their use of drugs and breaking away from the culture gave them the perfect opportunity.

The experiences of these 11 respondents hold two important lessons. First, homelessness involves exposure to hazardous social and physical environments and lifestyles but it is not inevitable that the risk factors associated with homelessness will impact on health. Second, the direct association between improvements in health and improvements in living environments suggest that raising standards in temporary accommodation would be a positive health intervention that could result in an improvement in the poor health profile of homeless people.

4.3 Case Studies.

I have avoided reference to individual health histories while exploring the proposition that homelessness is hazardous to health because it is difficult to unravel the biomedical processes

responsible for a specific episode of poor health and it would be misguided to make any claims about the *cause* of a respondent's health profile. I have, instead, explored the possibility that homelessness is hazardous to health by relating evidence regarding the impact of living conditions on health to the circumstances and situations respondents have lived in since becoming homeless. To conclude, however, it might be helpful if the plausibility of these associations between homelessness and health are illustrated with reference to three case studies.

1. Annie

Annie is 45 years old and has been homeless five years. Before becoming homeless Annie was living in a council flat in Edinburgh with her partner and was suffering from depression. Since becoming homeless, Annie's depression has got significantly worse. She is also experienced the onset of urinary problems, bronchitis and a weight problem (Table 4.1).

Table 4.1 Annie's health history and accommodation career since becoming homeless (ADC11)

<u>Time</u>	<u>Health care</u>	<u>Accommodation/Conditions/ Circumstances/Lifestyle</u>	<u>Health problems and changing health status</u>
- 1989	Registered GP Psychiatrist	Council flat with partner - Edinburgh <i>Conditions</i> - good <i>Happy?</i> - problems with partner	HEALTH PROBLEMS: Depression/anxiety/nervousness
1989 - 1990	No health care	Bed and Breakfast (private) - Edinburgh <i>Conditions</i> - Sharing room - no cooking - sharing bath/toilet <i>Happy?</i> - Safe and warm - No privacy - Lonely	NEW HEALTH PROBLEMS: Urinary problems EXISTING PROBLEMS WORSE: Depression
1990 - 11/91	No health care	Sleeping rough - Edinburgh <i>Conditions</i> - Cold/damp - Unhygienic <i>Happy?</i> - Unsafe/violence - Limited food - Insecure - Lonely	NEW HEALTH PROBLEMS: Bronchitis EXISTING PROBLEM WORSE: Depression
11/91 - 02/94	Psychiatrist	Hostel for homeless people (charity) - Edinburgh <i>Conditions</i> - Own room - No cooking - Sharing toilet/bathroom <i>Happy?</i> - Lonely/No support - Restrictions	HEALTH PROBLEMS WORSE: Manic depression NEW HEALTH PROBLEM: Over weight

Annie reported that since becoming homeless she has felt lonely, unsafe and insecure. She has lived in dirty, cramped and crowded accommodation and was exposed to cold, damp and violence when sleeping rough. Before becoming homeless Annie was receiving regular treatment from a psychiatrist. After becoming homeless she lost contact with her psychiatrist and received no health care or psychiatric support for two years, even though her manic depression got progressively worse. During the year she lived in bed and breakfast accommodation Annie experienced the onset of genito-urinary problems and during the year she slept rough experienced the onset of bronchitis. It seems reasonable to suggest that failure to receive health care could have exacerbated her deepening depression and the cold and damp of rooflessness could have precipitated the onset of bronchitis.

2. Nicky

Nicky is 27 years old and has been homeless one month. Before becoming homeless Nicky was living with her parents in a static caravan on a permanent site. When living at home she was experiencing depression and lethargy as well as suffering from learning difficulties. In the short time since becoming homeless her depression has improved and she no longer feels lethargic (Table 4.2).

Table 4.2 Nicky's health history and accommodation career since becoming homeless (CST6).

<u>Time</u>	<u>Health care</u>	<u>Accommodation/Conditions/ Circumstances/Lifestyle</u>	<u>Health problems and changing health status</u>
- 01/94	Registered GP Support re: learning difficulties	Parental home - Edinburgh Conditions - Own room - Good facilities Happy? - Problems with parents - Little freedom - Violence/harassment	HEALTH PROBLEMS: Depression Lethargy Learning difficulties
01/94 - 01/94	Support re: learning difficulties	Sharing with friends - Edinburgh Conditions - overcrowded - 3 people sharing 1 bed flat Happy? - Insecure/couldn't stay - Safe/away from violence	HEALTH PROBLEMS BETTER: Depression
01/94 - 03/94	Support and counselling from support staff. Support re: learning difficulties	Hostel for homeless women (charity) - Edinburgh Conditions - Own room - Good facilities/shared Happy? - Safe and secure - Privacy - Support - Restrictions - Food stolen	HEALTH PROBLEMS GONE: Lethargy/apathy HEALTH PROBLEMS BETTER: Depression

Nicky is one of 11 respondents whose health has improved since becoming homeless. When living at home she was subject to harassment and violence from her parents and had limited control over her own life. Since becoming homeless she has escaped the violence and harassment and received support and counselling from trained hostel staff. She now feels safe and secure and more in control of her life. Escaping harassment and violence and receiving support and counselling has coincided with an improvement in Nicky's health. Her depression has improved and the lethargy she had been suffering from has disappeared.

3. Cameron

Cameron is 21 years old and has been homeless five years. Before becoming homeless Cameron was living with his parents and had no health problems. Cameron left home following a disagreement with his parents. Soon after becoming homeless he started to experience a problem with drug use and subsequently related problems of lethargy and paranoia, as well as depression, mood swings and sleeping problems (Table 4.3).

There are some obvious associations between Cameron's accommodation and health histories. After leaving home Cameron moved in with friends and was exposed to a culture of drug use. It was while staying with these friends that Cameron started to suffer from a problem with drug use and, subsequently, lethargy, paranoia and depression. He stayed with friends for one year and following a disagreement moved into a hostel for homeless men. Cameron reported that conditions in the hostel were cramped and dirty, his life was restricted by rules and regulations and his personal safety was threatened by other residents. It was while living in this hostel that Cameron began suffering from mood swings. He got into a number of fights, was charged with assault and ended up in prison. On leaving prison he moved around Scotland staying with friends. He continued to experience a problem with drug use, lethargy, paranoia and depression, although he reported that his mood swings improved.

After three months Cameron no longer had any friends he could stay with and moved into a dormitory hostel for homeless men in Edinburgh. He reported that conditions in the hostel were crowded, dirty and unhygienic and that he felt unsafe and had little privacy. After being evicted for drug use he moved into another direct access hostel for homeless men where conditions were also crowded, dirty, unsafe and he lacked privacy. During the two months

Table 4.3 Cameron's health history and accommodation career since becoming homeless (BDG2).

<u>Time</u>	<u>Health care</u>	<u>Accommodation/conditions/ circumstances/lifestyle</u>	<u>Health problems and changing health status</u>
- 1989	Registered GP No health care	Parental home - Edinburgh <i>Conditions</i> - Good/own room <i>Happy?</i> - Problems with parents	HEALTH PROBLEMS: None
1989 - 10/92	No health care	Moving around - sharing with friends - Scotland <i>Conditions</i> - Sleeping on floors - crowded <i>Happy?</i> - No privacy - Insecurity - Drug culture	NEW HEALTH PROBLEMS: Drug dependency Lethargy Paranoia Depression
10/92 - 12/92	No health care	Hostel for homeless people - Lothian. <i>Conditions</i> - Shared room - Cramped/dirty <i>Happy?</i> - Restrictions annoying - Violence/unsafe	EXISTING PROBLEMS WORSE: Paranoia - mood swings
12/92 - 03/93	No health care	Prison	NO CHANGE IN HEALTH.
03/93 - 06/93	No health care	Moving around - sharing with friends - Scotland. <i>Conditions</i> - sharing rooms - sleeping on floors - crowded/dirty <i>Happy?</i> - Insecure - Drug culture	EXISTING PROBLEMS BETTER: Paranoia - mood swings
06/93 - 07/93	No health care	Hostel for homeless men (charity) - Edinburgh <i>Conditions</i> - Dormitory - crowded/dirty <i>Happy?</i> - Unsafe/Violence/Theft - Restrictions - No privacy/Noise - Insecure/evicted	NEW HEALTH PROBLEM: Sleeping problems EXISTING PROBLEM WORSE: Depression/stress
07/93 - 08/93	No health care	Hostel for homeless men (council) - Edinburgh <i>Conditions</i> - Unhygienic/cramped - Problems cooking <i>Happy?</i> - Little privacy - Restrictions - Unsafe	
08/93 - 02/94	No health care	Supported accommodation for young people (Housing assoc) - Edinburgh <i>Conditions</i> - Own room - Sharing flat with 6 - Crowded <i>Happy?</i> - Little privacy - Restrictions - Away from drugs	EXISTING PROBLEMS BETTER: Drug dependency Sleeping problems Depression Lethargy Paranoia

Cameron was living in hostel accommodation after leaving prison his depression got worse and he started having problems sleeping. For the last six months Cameron has lived in

supported accommodation for young people. Away from a culture of drug dependency, his drug use has declined. He reported feeling less stressed and finding it easier to sleep. However, Cameron is unhappy where he is currently living because he has little privacy, has to live within rules and regulations and has little personal space. Currently Cameron is suffering from a problem with drug use, sleeping problems, depression, lethargy and paranoia.

4.4 Conclusion.

In response to evidence that homeless people experience problems accessing and utilising health care, attempts to manage the health profile of homeless people have focused mainly on the provision of health care. The experiences of respondents reviewed in this chapter suggest that some homeless people continue to experience problems securing adequate and satisfactory health care despite the provision of special and separate services for homeless people. Respondents experiences also suggest that inadequate and unsatisfactory health care can exacerbate existing health problems. It is, therefore, important that homeless people have the guaranteed right to mainstream health care. Inadequate health care does not, however, offer a necessary or sufficient explanation of what causes ill health. The major determinants of ill health lie outside the health care field. Some of these are located in the living spaces occupied by homeless people. Relating evidence regarding the impact of living conditions on health to the poor physical conditions and distressing social circumstances respondents have lived in since becoming homeless, it has to be concluded that some of the problems respondents are experiencing stem from the conditions in which they have lived.

LEAVING HOME AND BECOMING HOMELESS

In Chapter Four I explored the possibility that homelessness is hazardous to health and suggested that the poor health profile of homeless people is, in part, a product of the poor physical and servicing environments in which homeless people often live. In Chapters Five and Six I explore the possibility that the poor health profile of homeless people is also, in part, a product of health selectivity out of and into the housing system.

It was revealed in Chapter Three that the majority of respondents had health problems before they became homeless. In this chapter I examine why, on leaving their last home, these respondents failed to secure permanent accommodation and became homeless. I then review longitudinal data on their resultant homeless accommodation careers.

5.1 Leaving Last Home.

Little research attention has been paid to the process of single people leaving permanent accommodation and becoming homeless, except in reference to younger people leaving the parental home. The reasons for this neglect are not clear but implicit in the political view of single homelessness is the suggestion that people become homeless out of choice. This sentiment is evident in the political response to homelessness. Under existing legislation, contained in Section III of the Housing Act 1985 and the Housing (Scotland) Act 1987, homeless people are only deemed deserving of permanent accommodation if they are judged to be unintentionally homeless (having not done or failed to do anything that resulted in their loss of home) and are in priority need because they have dependent children, are pregnant, are homeless following an emergency such as fire or flood or because they are 'vulnerable' because of old age, illness, disability or some other special reason. Since the boundaries

around vulnerability are frequently tightly drawn, most single homeless people have no statutory right to permanent housing. Furthermore, despite the restrictive nature of the current statutory framework, the government has recently voiced concern that the homeless legislation is being used as a 'fast track' into social housing. Implicit in their argument is the assumption that the legislation is a queue-jumpers charter and people are becoming homeless in order to secure council housing ahead of people on the waiting list. This belief led to the publication of the consultation document on homeless (DoE, 1994) and the 1995 White Paper on Housing in which the government argues for an end to the 'more attractive way' into housing via the homelessness route. However, the experiences of the homeless people interviewed in this study challenge the notion that homeless people are personally responsible for becoming and remaining homeless. Respondents were forced out of their last home against their will by factors over which they had little control, and had no option but to move into temporary accommodation.

For the purpose of this research, last home was defined as the last relatively secure, permanent accommodation a respondent lived in before moving into temporary accommodation or rooflessness (for example, their own house/flat or their parent's home where they had lived for at least six months). Data on last home was collected from 30 respondents (data could not be collected from 10 respondents - see Chapter Two). The majority of respondents were last at home in a rented flat or house (Table 5.1). Other last homes include the parental home, a mortgaged house and accommodation tied to employment.

As well as fixing last home using the definition of home as relatively secure, permanent accommodation, respondents were asked where they were living when they last felt at home. There are some differences between where respondents last felt at home and their last home as fixed by the definition of home as permanent accommodation, although the majority did report that they last felt at home when living in a rented flat or house. For example, the last home of nine younger respondents was fixed as the parental home. However, five of the nine reported that, rather than being a place they felt at home, the parental home was a place they were glad to leave either because of disagreements with their parents or because they had been mentally and physically abused.

Table 5.1 Last home - type of accommodation.

<u>Type of accommodation</u>	<u>Number of respondents</u>
Rented flat/house	17
<i>Local authority</i>	<i>(15)</i>
<i>Housing association</i>	<i>(1)</i>
<i>Private rented</i>	<i>(1)</i>
Owned flat/house	2
Parents' home	9
Tied accommodation	2
Total	30

Differences between last home as permanent accommodation and the last place a respondent felt at home are not surprising and illustrate the pitfalls of imposing any definition of homelessness. Home is more than bricks and mortar, it is a place rich in emotions (Veness, 1992). Home and homelessness mean different things to different people and no one definition can encapsulate all these meanings. However, working definitions are of use as long as their limitations are acknowledged. Equating home with permanent accommodation might label some people as 'at home' when they feel 'homeless' and label some people as 'homeless' when they feel 'at home', but it allows the point at which people last entered a severe housing crisis (lost secure, permanent accommodation) to be fixed and is therefore of use when examining the process of leaving permanent accommodation and exiting from the housing system.

All respondents were interviewed in Edinburgh. The majority of respondents were living in Scotland when last at home and over half were living in Edinburgh (Table 5.2). Eight respondents were living elsewhere in Britain, Ireland and Europe. Anderson et al. (1993) also found that nearly half of the 1500 homeless people they interviewed were staying in the same city as they lived in before becoming homeless, and local authority returns to the DoE show that most statutory homeless people in England originate from the locality where they present as homeless (Bramley, 1993). These findings question the assumption that single homeless people are transient and typically move from place to place on a regular basis, an excuse often

given for why GPs are reluctant to register homeless people on a permanent basis (see Chapter Four).

Table 5.2 Location of last home.

<u>Location</u>	<u>Number of respondents</u>
Edinburgh	13
Elsewhere in Scotland	9
England and Wales	6
Ireland	1
Outside Britain or Ireland	1
Total	30

5.1.1 Reasons for leaving last home.

Respondents were asked about the main reason why they left their last home and commonly referred to one particular event. It is important to point out that these data do not tell us why respondents became homeless. The events that affect people immediately prior to becoming homeless are not always the sole or main reason they become homeless. Homelessness is more likely to be a product of a series of events and circumstances and to be effected by a broader context (such as availability of housing and employment opportunities) than a sudden crisis such as relationship breakdown or job loss (Johnson et al., 1991). Therefore, I could not determine the role health might have played in the process of leaving home merely by asking respondents the main reason why they left home. This, however, was not my intention.

Understanding the process of leaving home would be a thesis in itself. The question of significance to this study is why people with health problems were unable to secure alternative permanent accommodation after leaving home and, consequently, became homeless. I asked respondents the main reason they left home for two reasons, first, to determine whether they left home out of choice and, second, because the immediate cause of homelessness is the only factor considered by a local authority when determining whether a homeless applicant is personally responsible for becoming homeless and, therefore, undeserving of help under the homeless legislation.

All 30 respondents identified one particular reason that finally made them leave their last home. The most common reason was family or relationship problems such as relationship breakdown, disagreement with parents and violence or abuse (Table 5.3). This finding concurs with the findings of previous studies. For example, Anderson et al. (1993) report that the majority of the 1500 single homeless people they interviewed gave family or relationship problems as the main reason for leaving their last home and DoE statistics show that relationship problems (parents or relatives unwilling to accommodate and marital breakdown) are the main reason given for being homelessness by homeless applicants for council housing in England (Bramley, 1993). Other reasons given by respondents for leaving their last home were eviction, harassment, health problems and out of choice.

Table 5.3 Main reason for leaving last home.

<u>Main reason for leaving home</u>	<u>Number of respondents</u>
Family or relationship problems	19
<i>Relationship breakdown</i>	(5)
<i>Violence or abuse</i>	(6)
<i>Conflict with parents</i>	(7)
<i>Death of partner</i>	(1)
Harassment	6
Eviction	3
<i>Tied accommodation</i>	(1)
<i>Private rented accommodation</i>	(1)
<i>Local authority accommodation</i>	(1)
Health problems	1
Out of choice	1
Total	30

Relationship breakdown

Five respondents, all aged between 25 and 40 years old, gave the breakdown of a relationship with a partner as the main reason why they left their last home. The relationship having ended,

all five reported they had no choice but to move out. Three of the five are men and were living with a partner and their children. Two were living in council housing and one was a owner occupier. All three reported that the relationship had irretrievably broken down and the only practical response was separation. Not wanting to force their former partner and children out of their home, they had no choice but to leave. Andy is one of these three respondents:

DR - Why did you leave the house you were living in with your with your partner?
ANDY - The relationship was more or less irretrievable and obviously, with having my daughter as well there was no way that I could put them on the street so it was me who said I would move out.
ADC3

The two other respondents who reported that relationship breakdown was the reason they left their last home also reported that the relationship with their partner had irretrievably broken down and separation was the only viable response. One was living in a house tied to her partner's employment and the other was living in a housing association flat the tenancy for which was in her partner's name. Consequently, both reported that they had no right to stay and had to move out.

One respondent left home following the death of his wife. Charlie is 65 years old and used to share a council flat with his wife. Charlie reported that following the death of his wife he could not cope with staying in the house, was getting more depressed and had attempted suicide:

DR - Why did you leave there (council flat)?
CHARLIE - Because it was in my mind that I was out of that area because round about reminded me of Sarah (*his wife*), I decided to get out of the area all together. I was unhappy and depressed and had to get away.
PSP7

Disagreement with parents.

Seven respondents reported that a disagreement with parents was the main reason why they left their last home. All seven reported that they had little choice but to move out after it became intolerable to stay because of disagreements over their lifestyle and behaviour. Six of the seven were less than 21 years old when they left home.

Furlong and Cooney (1990) identified four main reasons why young people leave the parental home - continuing education, starting a job, to marry or set up their own home or because of problems at home. However, patterns of leaving home vary by class and gender (Jones, 1987) and the risk of homelessness appears to increase when the reason for leaving home is more a matter of constraint than choice, for example, because of family conflict (Jones, 1995). Jones (1995) reports that 60% of young homeless Scots left their parental home because they did not get on with the people living there, and studies in England have also found that conflict with parents is a common reason for leaving home among young people who become homeless (Randall, 1989; Strathdee, 1989).

Violence or abuse.

Six respondents reported that the main reason they left their last home was because of violence or abuse from people they were living with. Two respondents left the parental home in order to escape physical and mental abuse. Rachel was 16 years old when she left home one year ago in an attempt to escape her violent mother:

DR - OK. You say that before you were living with your friend you were living with your mother down in the Borders, why did you leave there?

RACHEL - My mum was hitting me a lot. That's all a long story. My mum and her next door neighbour brainwashed me into believing that my dad had sexually abused me and my mum was like.... I was getting practically battered every day. I was just getting lectures every day. I couldn't do my work at school and I failed everything. I just one day said that I'm not taking this any more and I left. The minute I left home my grades started going up and I knew that home was the problem..... Aye. I thought that I was going to take a breakdown or something. I was like, I am going to crack up. I am really going to go crazy in a minute if I stay here any longer and it was going on and on and on and I was like, me mum would make me answer and it was like whack, and no this is not for me. I just didn't even live in my own home. I was at my next door neighbour's house and my next door neighbour used to hit me as well as my mum. The day I decided to leave home I just went through to my mum's house, got my stuff for school and collected my stuff for leaving home. I couldn't take a lot and I just walked out the door like I was just going to come back that night, and I rang her at 8 o'clock that night and said that I was never coming back. 'Come back and talk about it', that's what I don't want.

BDR 3

A link between leaving home and abuse among younger respondents concurs with the findings of previous studies. In a study of young people living in hostel accommodation in Scotland, Killeen (1988) found that 17% of residents had experienced sexual or physical abuse from their parents before becoming homeless and there appears to be a direct link between abuse

and young people running away from home before they are legally allowed (Hutson and Liddiard, 1994). In contrast, little attention has been paid to the plight of people who are forced to leave home in order to escape a violent partner. Violence within the home is a key reason why people, in particular women, leave home. For example, Anderson et al. (1993) report that 3% of the 1500 homeless people they interviewed left home because of violence within their home. Four respondents, all women, reported that the main reason they left home was to escape violence from a partner. Two of the four reported that they were scared for their safety following a particular violent incident and so moved out. The other two reported that they had been experiencing abuse for some time and had finally decided to get out.

Harassment.

Six respondents reported that the main reason they left their last home was because of harassment. All six were living in housing rented from the local authority and reported harassment ranging from noisy and annoying neighbours through to threats of violence. Respondents reported that over weeks or months the harassment made them feel unsafe, insecure and unable to carry on living in their home and they had no choice but to leave. Les is 42 years old and left his council flat two months ago following harassment:

DR - Why did you leave that flat?

LES - I was getting a lot of hassle and I wasn't getting any peace. I'd be lying in my bed and at four, five in the morning and someone would be at the door. Even at night time, I didn't get no peace at all....before I gave in the house all of the windows got turned in. I didn't want to know any more about it and I just walked away from the house and told the council I wasna going back.

PSP 4

Eviction.

Three respondents reported that they were forced to leave their last home by their landlord. All three were living in rented accommodation, two in a private tenancy and one in a council tenancy. The one respondent who was living in a council tenancy was evicted because he was judged to have abandoned the property. He disputed this fact, arguing that he had not abandoned the flat but had been staying at a drug rehabilitation centre on a temporary basis. However, he was still told to vacate the property. Of the two respondents who were evicted

from private rented accommodation, one reported that there was no apparent reason for her eviction and the other was evicted from tied accommodation after being made redundant.

Health problems.

Only one respondent reported that health problems were the main reason why he left home. Dan is 29 years old and left the council flat he was sharing with his partner in an attempt to escape the local drug culture and deal with his problem with drug use.

A common thread running through respondents' experiences is that they did not choose to leave their last home. Twenty-nine (29) out of 30 respondents reported that they were forced out of their accommodation against their will by factors out of their control. This is an important finding that challenges the assumption implicit in the political view of single homelessness that people choose to be homeless (DoE, 1994). The question now to be answered is why, after being forced to leave their last home, respondents failed to secure alternative permanent accommodation and became homeless.

5.2 Threatened with Homelessness - Searching for Accommodation.

Before leaving their last home, 25 out of 30 respondents were suffering from a range of mental and physical health problems, including respiratory problems, loss of consciousness, heart problems, alcohol and drug dependency, manic and suicidal depression and learning difficulties. In a number of cases these problems restricted everyday life and amounted to some degree of disability. It is commonly assumed that in Britain, a country with a welfare tradition, as far as housing provision is health selective it works in favour of people with health problems (Smith, 1990). This assumption reflects the social democratic tradition of state intervention in the housing system to achieve social goals that dominated post 1945 housing policy. Forced out of their homes and threatened with homelessness these 25 respondents should, therefore, have been able to access alternative permanent accommodation. However, all 30 respondents failed to secure permanent accommodation and became homeless.

5.2.1 Searching for permanent accommodation.

Respondents were asked about their attempts to secure permanent accommodation and avoid homelessness on leaving their last home. Significantly, only four respondents reported making any attempt to access permanent accommodation. Twenty-six (26) respondents reported that they had left home in a rush and had been unable to make any plans about where to stay in advance. Their first concern on leaving home was to secure a roof over their head and they decided that it was pointless to apply to local authorities, housing associations and private landlords, at least in the short term, because they would have to wait weeks or even months before they were offered accommodation. Instead, they concentrated on accessing temporary accommodation. Younger respondents also reported that when they left home they were unaware how to access housing. Therefore, despite the fact that none of the 26 wanted to become homeless and despite the fact that 21 were suffering from a range of mental and physical health problems, they all fell out of the housing system and into homelessness.

In theory, there is a safety net within the housing system that should prevent people with health problems becoming and remaining homeless. This is the high priority given to people with health problems among people eligible for council housing. This safety net did not prevent the 26 respondents who left home in a rush from becoming homeless, even though 21 were suffering from mental and physical health problems. In defence of the principle of health selectivity in favour of people with health problems, it could be argued that these 26 respondents left home and needed accommodation at such short notice that the safety net did not have time to respond to their need. The four respondents who did attempt to secure alternative permanent accommodation all had some warning that they might have to leave their last home, all applied to the council housing service for help but all became homeless.

Cathy decided that she could not take the abuse she had been receiving from her former partner any longer and Callum, Helen and Les reported that their circumstances became intolerable because of harassment. Consequently, they started making plans to find alternative housing. At this time, all four were suffering from health problems. Cathy was suffering from manic depression, Callum was suffering from asthma, depression and a problem with drug use, Helen was suffering from anxiety and exhaustion and Les was suffering from blackouts, respiratory problems, anxiety and had problems walking. However, housing provision was not

selective in their favour. They all failed in their attempt to secure permanent accommodation and became homeless.

Les, Callum and Helen were all living in council housing when last at home. Cathy was living in a housing association flat with her former partner. All four applied to the council housing service in an attempt to secure alternative permanent housing. Asked why they did not apply to housing associations, Les, Callum and Helen reported that they were unaware of local housing associations and the service they provide. Cathy reported that she thought an application to a housing association would not have time to be processed before she moved out. All four reported that they did not consider private renting because they could not afford to pay a deposit and rent in advance.

Les, Callum and Helen applied to the council for a transfer on the grounds of harassment and Cathy made a fresh application. Cathy was aware that applicants with health problems have high priority among people eligible for council housing and so mentioned all her health problems and supplied a supporting letter from her GP. In contrast, Les, Callum and Helen were not aware of the medical priority system and were not told about the system by council housing officers. Consequently, believing that health was of no relevance to their application and suspicious when asked about their health, all three withheld details of their health status from the council housing service. This finding raises a number of questions. Most important is whether the council housing service failed to tell these respondents about the medical priority system and failed to advise them to report all their health problems because they had no intention of enforcing the principle of medical priority. This question is dealt with in detail in Chapter Six where the efforts of 25 respondents to access council housing since becoming homeless are discussed. At this stage it will suffice to point out that faced with increasing demand for a declining stock, the council housing service has to ration supply and some applicants inevitably loose out.

Les and Callum were told by the council housing service that if they were determined to move out of their current council housing the only accommodation they would be offered in the near future was bed and breakfast accommodation. Subsequently, Callum took up this offer and moved into a bed and breakfast hotel. Les moved into a direct access hostel for homeless men. Helen was offered a temporary council flat. She accepted the offer but soon moved out and

into a women's refuge because she continued to experience harassment. Cathy was forced to leave her accommodation two weeks after submitting her application to the housing department. She had received no correspondence concerning her application and was forced to look for temporary accommodation. Therefore, all four respondents failed in their attempt to secure alternative permanent housing and were left with the choice of either moving into temporary accommodation or sleeping rough.

Twenty-six (26) respondents were forced to leave their last home at short notice and had to concentrate on accessing temporary accommodation rather than searching for alternative permanent accommodation. Four respondents had some warning that they might have to leave their home in the near future and so tried to secure alternative permanent accommodation with the council housing service but were unsuccessful. Therefore, 30 respondents, 25 of whom were suffering from mental and physical health problems, were forced out of the housing system and became homeless. Their experiences indicate that it is wrong to assume that housing provision selects in favour of people with health problems.

5.2.2 Searching for temporary accommodation.

Having left home and been unable to access alternative permanent accommodation, respondents started searching for temporary accommodation. Most started their search by approaching friends or relatives. Respondents without this option either approached a hostel, bed and breakfast accommodation or sought advice from friends, advice centres, the police or the council housing department. Most respondents moved in with friends or relatives. Others moved into hostels, bed and breakfast accommodation and a local authority temporary flat (Table 5.4). One respondent was unsuccessful in his attempts to access temporary accommodation and was forced to sleep rough and another respondent went travelling abroad.

Sixteen (16) respondents approached a friend or relative for accommodation on leaving their last home and all secured a bed for the night. Respondents reported that the friends or relatives they approached had known about the problems they were experiencing in their last home and had offered them a place to stay in an emergency. Staying with friends or relatives was typically a short term fix. Nine of the 16 respondents who moved in with friends or relatives stayed less than one month and only three stayed over four months.

Table 5.4 First place respondents stayed after leaving last home.

<u>Accommodation situation</u>	<u>Number of respondents</u>
Friends/relatives	16
Hostel	8
Bed and breakfast hotel	3
Sleeping rough	1
Local authority temporary flat	1
Travelling abroad	1
Total	30

Ten (10) respondents approached a direct access hostel for homeless people when they left home. Eight of the ten were granted access and secured a bed for the night. Two were refused access because the hostel they approached was full. They were referred to another hostel but both decided to take up a previous offer of help from a friend or relative. The eight respondents who secured hostel accommodation reported that they approached a hostel because they needed a bed immediately and had nowhere else to go. Four of the eight knew about local hostels before they left home. The other four found out about local hostels either through word of mouth, from an advice centre or the council housing department. Hostel accommodation proved nothing more than a short term fix for all eight respondents. Most stayed less than two months and then moved on to alternative temporary accommodation or slept rough.

Three respondents approached bed and breakfast accommodation when they left home. One respondent was given a list of bed and breakfast establishments that accept homeless people by the local authority social work department. He approached the hotels on the list but was refused access for no apparent reason. Unaware of any other temporary accommodation provision or where else to seek advice, he was forced to sleep on the street. The other two respondents who approached bed and breakfast accommodation both secured a bed for the night. Callum was referred by the council housing department (see 5.2.1) and Annie moved into a hotel that had been mentioned to her by a friend. Callum stayed in bed and breakfast accommodation for two months and Annie for over a year.

For most respondents, the move into temporary accommodation or rooflessness was the start of a complex homeless accommodation career. As revealed in Chapter Four, where people live determines what physical and social environments they are exposed to and, consequently, the potential for homelessness to impact on health. Also, as will be revealed in Chapter Six, the accommodation people live in when homeless is a key determinant of the help and support they receive in applying for permanent accommodation, the legitimacy of their application in the eyes of housing providers and, therefore, their chance of escaping homelessness. Therefore, in order to understand the relationship between homelessness and health it is important to understand homeless accommodation careers.

5.3 Homeless Accommodation Careers.

Homeless accommodation careers (a record of the different places people have lived since becoming homeless) were collected from all respondents, either back to their last home or for the preceding five years in the case of respondents whose last home could not be fixed. It is difficult to portray the complexity and unique nature of these careers. Some respondents have been homeless a matter of days, others for years. People have lived in numerous situations for different lengths of time at different points in their homeless accommodation career. I will discuss these complexities by, first, making general points about the use of different types of temporary accommodation and, second, by illustrating key points with reference to a number of case studies.

Respondents have stayed in a range of different temporary accommodation since becoming homeless (Table 5.5). The accommodation most respondents have stayed in is hostel accommodation, followed by sharing with friends or relatives, sleeping rough, supported accommodation and bed and breakfast accommodation. These accommodation settings have proved temporary and insecure. Table 5.6 shows the length of time respondents have stayed in accommodation settings since becoming homeless or in the last five years. Typically, a stay in accommodation has lasted less than two months. Respondents have, therefore, lived in a number of different accommodation settings. For example, one respondent (whose case is highlighted in section 5.4) has stayed in 12 different places in the nine months since he became homeless. These findings appear to confirm the insecurity of temporary accommodation reported by respondents and discussed in Chapter Four.

Table 5.5 Accommodation lived in since homeless/last 5 years.

<u>Accommodation type</u>	<u>Since homeless</u>	<u>Lived in during</u>	<u>Total</u>
		<u>last five years</u>	
Bed and breakfast hotel	4	2	6
Suppt'd accomm. for young people	8	-	8
Friends or relatives	18	1	19
Hostel	25	9	34
Own flat/house	2	-	2
Prison	3	1	4
Hospital	3	-	3
Sleeping rough	5	4	9
Lodging house/bedsit	1	2	3
Local authority temporary flat	3	-	3
Women's refuge	1	-	1
Squat	-	1	1
Resettlement unit	-	1	1
Alcohol unit	-	1	1
Travelling	2	1	3
<i>Base</i>	<i>30</i>	<i>10</i>	<i>40</i>

Table 5.6 Length of stay in accommodation.

<u>Length of stay</u>	<u>Number of stays</u>		<u>Total</u>
	<u>Since homeless</u>	<u>Last five years</u>	
Less than 1 month	47	8	55
1 to 2 month	21	1	22
2 to 6 month	16	2	18
6 months to a year	5	2	7
Over a year	8	10	18
Total	97	23	120
<i>Base*</i>	<i>24*</i>	<i>7*</i>	<i>31*</i>

*N.B. Figures do not include current accommodation and therefore exclude respondents who have lived in the same accommodation since becoming homeless or for the last five years.

5.3.1 Hostel accommodation.

Thirty-four (34) respondents have lived in hostel accommodation. Hostels vary in size, design, management, staffing and the people they aim to assist. Some are primarily concerned with the provision of accommodation. Others aim to assist particular groups of people, including broad groups, such as young people, and specific groups with 'special needs', such as people suffering from problems with alcohol use. Berthoud and Casey (1988) attempted to classify hostels in Britain according to their main client group. Of the 320 hostels they questioned 20% said their main purpose was to provide accommodation for people whose main need is housing, though they often provide care and support. The other hostels questioned said they provide support and/or rehabilitation to people with 'special needs'. Sifting through the various aims of different hostels, Berthoud and Casey (1988) came up with a classification of hostel accommodation. The most common type of hostel in their sample was hostels for ex-offenders, followed by hostels for housing only, women's refuges, hostels for the 'infirm', general hostels serving five or more needs, hostels for young people, drug and alcohol units, hostels for mothers and babies and 'others'.

Respondents were asked what service was provided by the hostels they have stayed in. The vast majority reported that their main purpose was to provide direct access accommodation for either men or women with nowhere else to stay. Respondents also reported staying in hostels providing support and accommodation for young people, for people suffering from problems with alcohol use, for people recently released from prison, for people with mental health problems and for women escaping violence.

Two obvious patterns of hostel use are evident in respondents careers. First, respondents have typically used hostels more the longer they have been homeless. The reason for this increased use of hostel accommodation appears to be that hostels are the last place respondents want to stay because of the poor physical conditions, social environment and rules and regulations (see Chapter Four). Therefore, they have avoided staying in hostel accommodation whenever possible. However, over time they have exhausted the alternatives (for example, staying with friends and relatives) and have been forced to stay in hostel accommodation or sleep rough. In addition, many respondents were unaware of hostel provision when they first became homeless. The second obvious pattern of hostel use is that hostel accommodation has typically

provided nothing more than a short term fix to respondents' accommodation crisis. The length of stay in a hostel varies between one night and 14 years but most stays have lasted less than four weeks. However, among older respondents (over 40 years old) most stays have lasted more than a year. The difference in length of stay in hostel accommodation between younger and older respondents appears to reflect the policies of certain hostels. For example, two respondents reported that their stay in a particular hostel was limited to two months because the hostel enforced a fixed, short term tenancy. However, an older respondent reported that he has been living in the same hostel for over one year.

Accessing hostel accommodation.

Most respondents found out about different hostels from public and private agencies such as advice centres, day centres, the council housing department and social services but approached hostels independently, without introduction and with little idea what accommodation to expect. Therefore, respondents have rarely made an informed choice about which hostel to move into, although their knowledge of available accommodation has increased the longer they have been homeless.

Only six respondents reported that they have been referred to a hostel by an agency. Two were referred informally by the local authority housing department who phoned a general needs hostel on their behalf and arranged an interview. It is not clear why these two respondents received assistance from the housing department. Other respondents who have approached the council housing service for help finding temporary accommodation have either been given a list of hostels and bed and breakfast hotels willing to accommodate homeless people or told to go to a particular hostel. Variable treatment may reflect the different practices of different members of staff or practical issues, such as the pressures on staff at the time a respondent sought help, but could effect a person's chances of securing accommodation. The other four respondents who have been referred to a hostel by an agency were referred to direct access hostels by either a social worker, the police or a centralised hostel access service that links people needing accommodation to hostels with bed space.

All respondents went through some kind of admissions procedure when they approached a hostel but none was aware on what grounds access was granted or denied. Given the variety of

hostels that exist, it is difficult to draw conclusions about how access to hostels is determined and why people are excluded (Anderson, 1994). This is especially true when hostels do not have set admissions procedures. Randall and Brown (1993), in their evaluation of the 'rough sleeper's initiative', found that while most hostels surveyed were having to restrict access because demand exceeded available bed space, they did not appear to have set priorities or well defined procedures governing access. The nature of the admissions procedures respondents have experienced range from a meeting with a member of staff in which they were told about hostel rules and asked if they wanted to stay (for example, in dormitory hostels), through to detailed discussion about personal circumstance, their accommodation history and support needs (for example, in 'special needs' hostels). Respondents who have stayed in dormitory hotels reported that they thought access depended solely on whether or not the hostel had space. Respondents who have accessed hostel accommodation through a more rigorous admissions procedure typically reported that they thought access was dependent on their needs matching the hostels aims. These thoughts concur with Garside et al.'s (1990) conclusion that where selection does exist it seems to be related to the overall aims of the project, the main criteria being age, gender, ethnic origin and degree of support required. Ten (10) respondents reported being refused access to a hostel. Most of the 10 reported that they think they were refused because the hostel was full. Others reported that it was because they had rent arrears with the council or because the hostel could not provide the care and support they needed.

Questions about health and well being were part of the hostel application procedure for most respondents. However, the interest in applicants health typically focused on the use of drugs and alcohol, reflecting the no alcohol/no drugs policy of most hostels. Well aware of this fact, respondents suffering from a problem with alcohol or drug use denied their problem. Most respondents reported that they have not volunteered any information when asked about their health by hostel staff. Asked why not, they reported that their health is relevant to an application and best not mentioned.

An interesting finding is that the longer respondents have been homeless the more they have learnt about the rules and regulations of different hostels and been able to maximise their chances of success in accessing accommodation. For example, after leaving the home he had shared with his partner and child, Andy moved in with a friend. However, he was soon asked

to leave and forced to look for alternative accommodation. At this time, Andy had no idea about what accommodation was available:

DR - When you were staying at your friends, when you found out he had to go and you were going to have to move out, what did you do?

ANDY - I only had 48 hours notice. The first place that I called was the CAB who put me in touch with Edinburgh council. I went to Edinburgh council. They gave me two numbers for B and B and put me in touch with 'hostel A' (council hostel) but they had no vacancies at that time so then they told me about the 'hostel B' (charity hostel).

DR - Did you go along to 'hostel B' then?

ANDY - Yeah.

DR - Did you know what to expect when you approached 'hostel B'?

ANDY - No, not at all. I got quite a shock. My idea of homelessness was 90 beds in a row which is basically what 'hostel B' is like but on a smaller scale.

ADC3

Andy was offered a bed and moved into hostel B. However, he was unhappy and looked for alternative accommodation. First he approached a local advice centre for homeless people where he found out about various local hostels, the accommodation they provide and the help they offer. He then set about accessing what he referred to as 'the Roll Royce of hostels' (hostel C), a council run hostel he heard had a good track record for helping tenants secure permanent accommodation and where conditions were better than the hostel he was in:

DR - Why did you leave 'hostel B'?

ANDY - The reason I done that was that 'hostel C' has so much say, they have so much clout as it were and it's advantageous to me to get into 'hostel C', apart from the fact that it is a beautiful building and it is clean and it is tidy and it is quiet, so the only way that I could do that was by leaving 'hostel B'.

DR - How did you find out about 'hostel C'?

ANDY - Through the Advice Centre.

DR - So, you left 'hostel B'. Did you approach anywhere else for accommodation?

ANDY - No, 'cause financially I couldn't and I had heard that there would be vacancies coming up at 'hostel C'. I didn't leave spur of the moment. I did a bit of research to see what was happening up at 'hostel C' and I knew there would be vacancies. If you are in this situation you look after yourself and obviously if you can get into a position to make yourself better than obviously you are going to do it at whatever the cost to get back on your feet again. I just kept phoning 'hostel C' everyday and one morning I phoned up 7 in the morning and said is there any vacancies. Yes could you come up for an interview at 9 o'clock.

DR - Before you approached 'hostel C', you knew what they were about?

ANDY - Yeah and I knew that I would stand a better chance of getting a flat....I felt much more comfortable in 'hostel C', it's a far better environment. I knew that 'hostel C' would guarantee me a property.

DR - Why?

ANDY - Well, 'hostel C', they also have housing officers there who have a computer direct link with Edinburgh council. For a start when you move into 'hostel C' you get an extra 40 points from what I was getting in the 'hostel B'. They have a direct link

with the computer at Waterloo Place (housing department) so they can tell you exactly what is available and between the lines they have quite a big clout with housing associations for example. Edinvar (housing association), I went for an interview with Edinvar while living at 'hostel B', Edinvar told me it would be 12 months. I moved into 'hostel C' and with 2 weeks I had a second interview with Edinvar and I was offered a flat, so.

DR - Why does living in 'hostel C' make such a big difference to living in the 'hostel B', both of them are hostels and if anything 'hostel B' is a lot worse?

ANDY - Yeah, I think it is something to do, it's £463 a week to stay at 'hostel C' which comes from local government so at the end of the year 'hostel C' have got to put in statistics to say that out of the people we had in here 89% are back in the community and rehoused so therefore they must justify the money they spend. They do have social workers and they do have an outreach team there, people who have a direct link with them.

ADC3

Few respondents have been as calculating as Andy in negotiating access to hostel accommodation. Why is not clear, although bargaining power is likely to be related to knowledge which in turn is likely to reflect formal and informal advice and support. Many respondents have, however, gained a knowledge of hostel accommodation above and beyond what they knew on first becoming homeless and have used this knowledge to give them an advantage in accessing the best hostel accommodation.

Summary

Most respondents do not want to live in hostel accommodation and have avoided doing so for as long as possible. However, having exhausted the alternatives, the majority of respondents have been forced to stay in hostel accommodation. Typically, respondents have not made an informed choice about which hostel to stay in. They have approached a hostel because they were advised to do so either by other homeless people or by public and private agencies, such as advice centres and the council housing department. However, the longer respondents have been homeless, the more experience they have gained about available hostel accommodation and how to maximise their chances of accessing the best accommodation.

5.3.2 Staying with friends or relatives.

Nineteen (19) respondents have lived with friends or relatives since becoming homeless. Before moving in with friends or relatives most respondents were living at home (Table 5.7). After leaving, most respondents moved into hostel accommodation. The length of time

respondents have stayed with friends and relatives varies between one night and a year but most stays lasted less than four weeks. Respondents typically reported that they were hoping for nothing more than a bed for the night when they approached a friend or relative and only did so as an emergency measure until they secured alternative temporary accommodation.

Table 5.7 Moving in and out of friends and relatives.

<u>Accommodation before moving in</u>		<u>Accommodation after moving out</u>	
Home	16	Hostel	10
Hostel	4	Friends and relatives	3
Friends and relatives	3	Supp'ted accomm.	3
Bed and breakfast	1	Prison	1
Sleeping rough	1	Boarding school	1

N.B. Some respondents have moved in and out more than once and some are currently living with friends or relatives. Therefore, the figures in the two columns do not correspond with each other or add up to 19.

The vast majority of respondents who have stayed with friends and relatives only did so early in their homeless accommodation career. The declining reliance on friends and relatives is a reflection of the problems respondents have encountered sharing accommodation and the fact that access is dependent on a friend or relative having space and agreeing to help. Respondents reported that sharing with a friend or relative is difficult, disagreements are inevitable and, consequently, friends or relatives are not willing to help out indefinitely. Therefore, the longer respondents have been homeless the less they have been able to rely on the help of friends or relatives. Jones (1995) reports similar experiences among young people leaving the parental home. Some respondents have, however, continued to stay with friends and relatives on and off throughout their homeless accommodation career, although stays have been limited to emergencies, for example, when unable to secure alternative accommodation and facing a night on the street.

The fact that 19 out of 40 respondents have stayed with friends or relatives and the majority (16) did so immediately on becoming homeless is an important finding. People staying with friends or relatives are not recognised as homeless in official statistics or accounted for in

surveys of hostel dwellers and people sleeping rough. They are also invisible to service providers who target people living in hostel accommodation and sleeping rough. Therefore, they might have been neglected by official services at a time when they were needing help, support and advice, above and beyond the informal support provided by friends or relatives, to help them cope with the trauma of becoming homeless and negotiate their escape from homelessness.

5.3.3 Sleeping rough.

Nine respondents (seven men and two women) have slept rough. Among these nine respondents there are two distinctive experiences of sleeping rough. Four respondents have only slept rough for a short time between stays in accommodation. None of these four wanted to sleep rough but they had no choice but to do so after being forced out of accommodation (sharing with a friend, a hostel, supported accommodation and last home) at short notice and knowing of nowhere to stay. While sleeping rough all four respondents sought and secured hostel accommodation or a place with a relative.

For the five other respondents sleeping rough is not a brief experience but their primary mode of living. They have been sleeping rough for months or even years. However, it would be wrong to assume that these homeless people have chosen to remain on the street and accept the hazards that sleeping rough inevitably involves. Only one of the five reported that he wants to sleep rough. The other four all reported that they would prefer their own flat or house but, faced with the option of sleeping rough or staying in a hostel, they preferred to sleep rough because of previous 'bad experiences' in hostel accommodation, such as threats of and actual violence. They did, however, sometimes stay in a hostel or with a friend, for example, when it was particularly cold.

5.3.4 Supported accommodation

Most supported accommodation schemes are directly or indirectly managed by housing associations. Different schemes cater for different groups of people. The resident group can be very broad, for example, young people, and very specific, for example, people with particular health problems. Watson and Cooper (1992), in their study of 385 supported accommodation

schemes in England, found that the great majority of schemes offer shared housing. They also found that length of stay varies depending on the type of scheme. For example, in schemes for people with mental and physical disability and frail elderly people around 95% of stays were over three years. However, in schemes catering for women leaving violence, young people and single homeless people most stays were less than three years and many were less than one year.

Eight respondents have stayed in supported accommodation, all in accommodation for young people. Only one of the eight has moved out of supported accommodation. Gill was evicted after two months because of violent behaviour and subsequently moved in with a friend. All eight respondents had been homeless over two months before moving in. Six were living in hostel accommodation immediately before moving in, one was in bed and breakfast accommodation and one was lodging at a boarding school. The range of support they have received has varied depending on their needs and the aims of the project. Three respondents are staying in a scheme that aims to help young people with budgeting problems, day to day finances and the practicalities of living independently, two are staying in a scheme that aims to help young people with health problems and two are staying in a scheme that aims to help young homeless people. These schemes provide either 24 hour cover, visiting support or support during office hours.

Only eight respondents have applied to a supported accommodation project. Each made a number of applications to different projects but only received one offer. Respondents are unaware why they were offered accommodation but assume that it was because their needs matched the projects aims. Similarly, they are unaware why their other applications were unsuccessful but assume that it was because their needs did not match the project's aims. Typically, respondents held back information on their health when applying to supported accommodation, even when asked specific questions about their health status. Callum has a history of drug abuse, depression and asthma. On applying to supported accommodation for young people needing help and support to live independently he chose not to refer to his drug problem or the depression he was experiencing because he thought it might jeopardise his application:

DR - Did they ask you anything about your health on the form or in the interview?
CALLUM - Aye. I told them I was an asthmatic.

DR - Did you mention any other problems?
 CALLUM - No.
 DR - Why not?
 CALLUM - The drugs was getting better and it's not the best thing to say when you are wanting a place to live, 'I'm a junkie by the way'.
 DR - Would your health have affected their decision?
 CALLUM - Aye, yeah, probably it would of.
 BDG1

However, when applying to projects catering for people with emotional, practical and mental health problems, some respondents highlighted their health problems in the hope of increasing their chance of success. Cameron approached a supported scheme providing help to young people with health problems. Cameron has a history of drug abuse and related problems such as flashbacks, lethargy, paranoia and sleeping problems. He was aware of the aims of the scheme and sought to increase his chances of success by referring to his health problems:

DR - Did you tell them you had drug problems?
 CAMERON - Aye and then they started pushing to go see a doctor.
 DR - Did they ask you anything else about your health?
 CAMERON - They asked if I had any other health problems and I said no and they asked me to go to a doctor to get it checked out and I said aye 'cause it does help now if you have got a medical problem. If you can get a letter saying that this person needs to move out of this accommodation 'cause the noise keeps him up and he feels a threat because of the people in the flat.
 DR - Did you say anything like that?
 CAMERON - Aye. I said that I feel threatened 'cause there is three alcoholics living in my flat ranting and raving and I'm afraid that I am going to attack me.
 DR - Do you think that your health and saying those things affected their decision?
 CAMERON - I think, I don't know if it made any difference but if you had a health problem it would of almost automatically got you in.
 BDG2

Help or advice was the key to why eight respondents approached supported accommodation and why 32 respondents have not. All of the eight respondents who have applied to supported accommodation did so with help and advice from either a social worker, support worker or member of staff at a hostel. The 32 respondents who have not applied reported that they are either unaware of the service provided by supported accommodation projects, how to apply or that such projects exist. This is an important finding. Since they moved into supported accommodation respondents have lived in an improved physical and social environment and received regular advice and support that has helped them to cope with and plan their escape from homelessness. It is possible that living in these circumstances will be less health threatening than the situations in which they were living before (hostel and bed and breakfast

accommodation) and will also offer a better opportunity for securing permanent accommodation. However, it was only luck - a chance contact with hostel staff, a support worker or a social worker who was aware of local supported accommodation projects and willing to refer them - that resulted in their application.

5.3.5 Bed and breakfast accommodation.

Six respondents have stayed in bed and breakfast accommodation since becoming homeless. Some bed and breakfast hotels cater solely for the holiday trade, others provide residential accommodation during the off season and some cater entirely for people needing somewhere to live. The aim of all is to make money. Care, support and rehabilitation are not on offer. Bed and breakfast hotels catering specifically for homeless people have their income guaranteed by Housing Benefit payments. By exploiting this system some owners have generated considerable income, providing bed and breakfast accommodation to homeless people at artificially inflated prices, safe in the knowledge that there is no public control of charges and payment is guaranteed (Conway and Kemp, 1985).

Homeless people living in bed and breakfast accommodation fall into two main groups (Conway and Kemp, 1985). First there are households, mostly families with children, who have been placed in bed and breakfast accommodation by the local authority housing department under the Housing (Homeless) Persons Act. Second, there are people, most of whom are single people and childless couples, who have found their own way into bed and breakfast accommodation. The vast majority of people in bed and breakfast hotels fall into this second group (Conway and Kemp, 1985). Among the six respondents who have stayed in bed and breakfast accommodation, one was placed there by the local authority (Callum's case is discussed in section 5.2). The other five respondents found their own way into bed and breakfast accommodation. Previously they were living at home, in hostel accommodation and in another bed and breakfast hotel.

Four of the five respondents who found their own way into bed and breakfast accommodation stayed in hotels catering specifically for homeless people. They found out about bed and breakfast accommodation from other homeless people or from the local authority housing department. They reported that access appeared to be based on the whim of the owner and

were unaware why they had been turned away from some hotels yet accepted by others. These four respondents have only stayed in bed and breakfast accommodation once and their stay lasted at least six months. Asked why they have not since stayed in bed and breakfast accommodation they all referred to the cramped, dirty, hazardous and unhygienic conditions that they had to live in, the rules and regulations that had governed their lives and their unwillingness to live under such circumstances again. The one other respondent who has lived in a number of bed and breakfast hotels stayed in hotels catering for the holiday trade. Charlie has moved from town to town every few weeks since he became homeless nine months ago. After first becoming homeless he stayed in bed and breakfast hotels catering for the holiday trade because he knew nowhere else to go, paying for his room out of his savings. Since his savings ran out he has lived in hostel accommodation.

5.3.6 Case studies.

Each respondent has a unique and often complex homeless accommodation career. It is clear, however, from the above discussion that these careers are full of common experiences. To illustrate these unique and complex careers and highlight the common experiences I will reference some typical and not so typical careers.

Thirty-one (31) respondents have lived in more than one place since becoming homeless, or in the last five years, and their stay in each place has typically lasted less than two months. The accommodation respondents have stayed in has usually provided a short term fix rather than a long term solution or escape route out of homelessness. Most respondents reported that they did not chose to leave accommodation but were forced to do so either because they were told to leave or felt unable to stay. Charlie's homeless accommodation career highlights these findings (Table 5.8).

Charlie reported that he left his home nine months ago following the death of his wife in an attempt to escape memories that were making him depressed and led him to attempt suicide. At this time he was also suffering from angina. Charlie has spent the last nine months moving around England and Scotland and has stayed in 12 different places, never for longer than two months in any one place. He reported that on most occasions he did not leave accommodation out of choice but because he was unhappy, scared or because his tenancy had expired.

Table 5.8 Charlie's homeless accommodation career (PSP 7).

<u>Time</u>	<u>Accommodation and location</u>
- 04/93	Last home - council house. Location - Derby
1. 04/93 - 05/93	Bed and breakfast hotel Location - Aberdeen
2. 05/93 - 06/93	Hostel for homeless men (Salvation Army) Location - Edinburgh
3. 06/93 - 07/93	Hostel for homeless men (council) Location - Newcastle Upon Tyne
4. 07/93 - 07/93	Hospital Location - Newcastle Upon Tyne
5. 07/93 - 07/93	Hostel for homeless men (Salvation Army) Location - Darlington
6. 07/93 - 09/93	Bed and Breakfast hotel Location - Sheffield
7. 09/93 - 11/93	Bed and Breakfast hotel Location - Southampton
8. 11/93 - 11/93	Staying with friends Location - Birmingham
9. 11/93 - 12/93	Bed and breakfast hotel Location - Birmingham
10. 12/93 - 11/93	Hostel for homeless men (charity) Location - Edinburgh
11. 12/93 - 01/94	Hospital Location - Edinburgh
12. 01/94 -	Hostel for homeless men (charity) Location - Edinburgh

Initially, he stayed in bed and breakfast accommodation which he paid for out of his savings. When he was unable to find bed and breakfast accommodation, and since his money has ran out, he has stayed in hostel accommodation. Charlie has been admitted to hospital on two

occasions since becoming homeless, in both instances when attending an A and E department to pick up a prescription for angina. Charlie's experience of living in numerous different accommodation settings and staying in each a short period of time is typical of most respondents. Few respondents have, however, moved from town to town as much as Charlie.

Respondents who have been homeless for a number of years tend to have moved accommodation less and stayed in accommodation longer. For example, Harry and Robbie have both lived in the same accommodation setting for at least the last 10 years. Harry is 50 years old and suffers from schizophrenia. He left psychiatric care in 1980 and has lived in the same dormitory hostel for homeless men ever since. He is not happy living in hostel accommodation and reported that conditions are poor and he does not receive the care and support he needs. Asked why he has not moved out, Harry reported that he does not know where he could move to and has received no help looking for somewhere else to stay. Robbie is 68 years old and is suffering from arthritis, sleeping problems, kidney problems, a problem with alcohol use and walking problems. Robbie reported that he has been living in the same dormitory hostel for the last 10 years. Robbie reported that conditions are adequate in the hostel but he would like a room of his own. Asked why he has not moved out and got a room of his own, Robbie reported that he does not know where to look.

Willie is 20 years old and has been homeless since he was 15. He is suffering from scabies, depression, drug abuse, paranoia and weight loss. In the last five years he has lived on the streets, in hostels, with friends and in prison (Table 5.9). Like Charlie, Willie has stayed in places for a short time and lived in a range of different accommodation situations. However, his history is different to Charlie's and typical in that he has not moved geographically. It is commonly assumed that homeless people lead a transient lifestyle, moving from town to town on a regular basis. This is certainly true in Charlie's case. This transient lifestyle is often blamed for the unwillingness of GPs to register homeless people on a permanent basis and the lack of quality and continuity in the provision of health care for homeless people. However, most respondents were living in or around Edinburgh before they became homeless and have not left the area since becoming homeless.

Table 5.9 Willie's homeless accommodation career (ADC 7)

<u>Time</u>	<u>Accommodation and location</u>
1. 1989 - 11/92	Sleeping rough, staying in hostels when cold Location - Edinburgh
2. 11/92 - 11/93	Prison
3. 11/93 - 12/93	Sleeping rough Location - Edinburgh
4. 12/93 - 12/93	Hostel for homeless men (charity) Location - Edinburgh
5. 12/93 - 01/94	Hostel for homeless men (council) Location - Edinburgh
6. 01/94 -	Sleeping rough, staying with friends when cold Location - Edinburgh

Respondents have often lived in different accommodation at different times since becoming homeless. Most respondents who have lived with friends or relatives did so when first homeless and respondents have tended to stay in hostel and supported accommodation more the longer they have been homeless. Lesley's accommodation career illustrates this pattern of accommodation use (Table 5.10). Lesley is 17 years old and has been homeless for seven months. Lesley reported that when she left home she was unaware of what temporary accommodation was available and moved in with a friend who had offered to let her stay. However, she had to leave after a couple of weeks following a disagreement. Having no other friends or relatives to stay with and unaware of alternative accommodation, Lesley sought help from the Citizens Advice Bureau. She was told about a hostel for young people, approached the hostel and moved in within the day. Hostel staff actively helped and encouraged Lesley to search for alternative accommodation and recommended she apply to a project providing supported accommodation for young people. Aware that hostel policy only allowed a maximum eight week stay (accept in extenuating circumstances, for example, if alternative accommodation had been secured but was not yet available), she accepted the help

and was referred by staff to a supported accommodation project. Subsequently, her application was successful and she moved in.

Table 5.10 Lesley's homeless accommodation career (BDR 1).

<u>Time</u>	<u>Accommodation and location</u>
- 12/92	Parental home Location - West Lothian
1. 12/92 - 01/94	Staying with friends Location - Edinburgh
2. 01/94 - 03/94	Hostel for homeless young people (charity) Location Edinburgh
3. 03/94 -	Supported accommodation (housing association) Location - Edinburgh

Health and advice has been an important factor in determining the nature of many respondents' homeless accommodation careers. Respondents have received help and advice from friends or relatives on where they can get a bed for the night and from public and private agencies about what accommodation is available, how to apply and how to maximise their chances of a successful application. However, the quality and quantity of advice that respondents have received appears to have little to do with need and a lot to do with the luck of a chance encounter with a person or agency willing and able to help.

5.4 Homeless Out of Choice?

Implicit in the popular and political view of homelessness is the assumption that single homeless people chose to be homeless and are therefore undeserving of help or assistance. In this Chapter I have revealed that the homeless people interviewed in this study did not want to become homeless but were forced out of their last home against their will by factors over which they had little control, and had no option but to move into temporary accommodation. Since becoming homeless they have had limited control over their accommodation careers.

Respondents also reported that they do not want to be homeless. They want their own independent, self-contained flat or house (Table 5.11).

Thirty-six (36) out of 40 respondents want their own home. Four younger respondents reported that they want to move into supported accommodation that will provide them with the necessary knowledge and skills to live independently and will act as a stepping stone to their own flat or house. One older respondent reported that he wants to live in a old people's home where he will be assured of help and support and one younger respondent reported that he wants to move back in with his parents. Thirty respondents reported that they want their own independent, self-contained house or flat because it would give them the privacy, freedom, independence, control, security, self esteem, warmth, safety, belonging and potential for improving life chances that they need. These 30 respondents expressed modest desires, typically wanting a one or two bedroomed flat. What little tenure preference was expressed favoured renting over ownership because of the initial costs associated with owner occupation.

Table 5.11 The accommodation where respondents would like to live.

<u>Type of accommodation</u>	<u>Number of respondents</u>
Own flat/house	30
Supported accommodation	5
Lodging house	2
Parent's home	1
Current accommodation	2
Total	40

Only four respondents reported that they want to remain in their present situation or move into alternative temporary accommodation. Three of the four want to live in a lodging house and Mick reported that he wants to continue to sleep rough because he likes the freedom of not being tied to one place and sees sleeping rough as 'a way of life'. These four respondents accommodation preferences highlight that it is neither appropriate or accurate to assume that everyone who does not have 'their own home' considers themselves 'homeless' or in urgent need of alternative accommodation (Anderson, 1994). However, the vast majority of respondents reported that they did not want to become and do not want to remain homeless.

5.5 Conclusion.

There are two key points to take from this Chapter. First, respondents were forced to leave home, did not want to become homeless, have lived in accommodation settings they would rather have avoided and do not want to remain homeless. These are important findings because they challenge the popular and political view of single homelessness that has dominated policy debates about the causes of homelessness. The assumption that single people are personally responsible for becoming and remaining homeless has allowed policy-makers to label single homeless people as undeserving and to excuse their failure to tackle the problem (see Chapter Seven). However, the experiences of the people interviewed in this study expose this assumption as a divisive misrepresentation of the forces that shape the experiences of single homeless people.

The second key point to take from this Chapter is that the majority of respondents had health problems before they became homeless but were still forced to leave home, failed to secure alternative permanent accommodation and became homeless. These experiences suggest that housing provision is not selective in favour of people with health problems. However, although people with health problems are becoming homeless, once they are homeless and have secured temporary accommodation they will have the time to search for permanent accommodation, and housing providers will have more time to identify and respond to their needs. Given the high priority people in medical and housing need have among people eligible for council housing, homeless people with health problems should not, therefore, remain homeless for long. Whether or not this is true is the focus of Chapter Six.

ESCAPING HOMELESSNESS: ACCESSING PERMANENT HOUSING.

In Chapter Five it was revealed that housing provision is sometimes failing to ensure that people with health problems are retained in permanent accommodation. The safety net to prevent them from *exiting* the housing system is not in place. Exit from the housing system is selective for poor health. In this Chapter I discuss respondents' attempts to escape homelessness and explore the related question of whether or not *re-entry* into the housing system is selective in favour of people with health problems. In doing so I will focus on respondents' attempts to access private rented, housing association and local authority housing and examine the rules and procedures that govern selection and allocation in each of these sectors. No reference is made to the owner-occupied sector because no respondent made any attempt to access the owner occupied sector and few reported even considering home ownership because of the costs involved.

6.1 Escaping Homelessness - Accessing Private Rented Housing

Throughout the twentieth century the proportion of the housing stock that is privately rented has declined. Whereas once the vast majority of dwellings were privately rented, by 1990 the proportion of dwellings let privately had declined to around 9% (Rauta and Pickering, 1992). The Housing Act 1980 was introduced in the face of this ongoing decline. Amongst other things, the act liberalised rent control and created short-hold and assured tenancies. However, the 1980 Act failed to achieve a revival of the sector and decline continued (Kemp, 1988). A further attempt was made to revive the sector with the 1988 Housing Act. The main feature of the 1988 Act was the deregulation of future lettings, the argument being that rent controls encourage landlords to disinvest and discourage new build for private letting. Underlying

deregulation was a belief in the efficiency of the free market and its superiority over state intervention (Kemp, 1988). Between 1988 and 1990 actual rents increased by 43%, from an average of £30 per week to £43 per week. In the new Assured Short-hold and Assured tenancies rents were much higher than average, £66 per week in Assured Short-hold tenancies and £61 per week in Assured tenancies. Although deregulation has been justified by free market reasoning, rent increases have been underpinned by state intervention in the form of Housing Benefit payments that help people on low incomes with the cost of housing. As rents have increased so the Housing Benefit bill has rocketed. In response, rather than introducing rent controls the government is to limit the Housing Benefit budget by setting a ceiling on the level of payments to people on low incomes. The impact of these Housing Benefit changes is unknown but it has been suggested that the changes will worsen affordability, pushing thousands of private renting households into poverty and increasing dependency on housing benefit (Bramley, 1995).

Despite many years of decline and decay the private rented sector continues to fulfil a number of key roles (Kemp, 1988). First, it houses many people who have lived in privately rented housing for a number of years, often back to when it was the majority tenure. Secondly, the sector provides a flexible housing option for people who are geographically mobile, for example students and other young single people (Jones, 1995). Thirdly, the sector provides employment related accommodation. Fourthly, the sector performs a residual role, housing people unable to access local authority and housing association accommodation and who cannot afford owner occupation. Therefore, the private rented sector is often seen as an appropriate housing option for single people (Anderson, 1994). However, there is little understanding of the opportunities that private renting offers single homeless people in light of recent deregulation, subsequent rent increases and the growth of short term tenancies.

The experience of respondents in this study is that private renting does not offer single homeless people an escape route out of homelessness. The private rented sector is free from bureaucratic constraints of waiting lists and statutory obligations. Access is determined by choice, availability and most importantly, ability to pay. Thirty-eight (38) out of 40 respondents reported that they have not attempted to access private rented permanent accommodation since becoming homeless because they cannot afford the costs involved. The two respondents who have looked for private rented accommodation both approached a

landlord after seeing an advert in a local paper but neither had enough money to pay the deposit, which in both cases was over £300. Neither has since looked for private rented accommodation.

Anderson et al. (1993) identify two separate affordability problems in the private rented sector. First, people have difficulty raising deposits and rent that are usually payable in advance. Most respondents reported that they have not looked for private rented accommodation because they cannot afford to pay a deposit and rent in advance. Up until 1988, and the introduction of the Social Fund, social security claimants could receive some assistance with deposits through the single payments scheme. However, since the introduction of the Social Fund, rent and deposit payments have been a low priority in the allocation of fund resources, and the payment of deposits or rent in advance has become the principal barrier preventing single people on low incomes from accessing privately rented housing (Anderson, 1994).

A second affordability problem in the private rented sector is that rents are higher than people can afford. Three respondents have not looked for private rented housing because they fear being caught in the trap of taking on a high rent when unemployed (when the rent is paid by Housing Benefit) and then being saddled with payment when they get a job and housing benefit entitlement is removed. Andy is one of these three respondents:

DR - Have you approached any private landlords or looked for private rented housing?
ANDY - No, the private sector I wasn't prepared to move into because it's OK now 'cause housing benefit pays it but when I go back to work you are talking rent in excess of £330 per month for the flat that I would want and I'm just not able to pay that, I would rather go for a mortgage again than do that but I can't afford that either.
ADC3

Whether or not respondents are aware of the introduction of restricted tenancies in 1988 is not clear, but it appears that they are all too aware of the consequences. Studies by Sharp (1991), Rhodes (1993) and Rauta and Pickering (1992) have identified a growth in short-hold tenancies that offer limited security to tenants. As well as the problem of affordability, a number of respondents referred to insecurity as a reason for not looking for private rented housing. As Pat put it:

PAT - Like, well, with the private landlords, I mean you are not a 100% guaranteed permanent residence which makes me a bit weary of them whereas with the council, unless you really fall behind in the rent or something major like that then you are practically guaranteed a house.
CST5

Respondents have also been put off from applying for private rented housing because they have seen 'no DSS' in adverts for private rented housing and two younger respondents reported that even if they could afford to rent privately they would not know how to go about accessing private rented housing. The private rented sector has, therefore, not presented respondents with an opportunity to escape homelessness and re-enter the housing system. Respondents have instead focused their attention on accessing housing association and local authority housing.

6.2 Escaping Homelessness - Accessing Housing Association Housing.

Over the past 20 years, housing associations have emerged as the politically favoured providers of social housing. In 1979 1.9% of all dwellings in Britain were housing association tenancies (DoE, 1990). The sector now provides around 3% of all dwellings (Anderson, 1994). 'Housing association' is used as a generic term to cover the various agencies that make up the voluntary housing movement. Under the Housing Act 1974, an association is a society, company or body of trustees with the objective of improving or managing houses and operating on a non-profit making basis (Malpass and Murie, 1990). The 1974 Act increased the allocation of funds to the Housing Corporation, the 'quango' that distributes public capital to housing associations in England (similar 'quangos' have since been given independence in Scotland and Wales - Scottish Homes and Tai Cymru), and outlined three main priorities for associations; to support the drive to improve housing conditions; to support an increase in new housing for rent and; to provide housing for 'special needs' groups (Short, 1982). Some housing associations aim to meet general needs, many focus on providing special housing or residential care to what is regarded as a readily definable group who are perceived to be in need, for example, older people, young people, people with physical disabilities, people with mental health problems and illnesses, single people and women at risk from violence (Clapham and Smith, 1990).

Significant changes in the funding of housing associations and tenancy arrangements were introduced in the Housing Act 1988. Prior to the 1988 Act the welfare of tenants was put first. Housing associations set fair rent levels and the government grant level was set to cover additional cost. Since 1988 the grant level has been fixed and rent has been the key variable adjusted to cover cost. To allow rents to be adjusted to cover costs, the 1988 Act also allowed associations to offer lets on assured tenancies for which the rent is negotiated between the tenant and the landlord, rather than on secure tenancies with 'fair rents' as was previously the case. The clear message from the government was that post 1988 rents should be higher than 'fair rents' and act as a lever to raise rents generally (Kearns, 1992). To this end the 1988 Act has been successful, the net result being less secure and more expensive tenancies (Harrison, 1992).

Surveys of tenants have found households living in housing association accommodation to be living on lower than average income, likely to be in receipt of benefits and often receiving some sort of support in their accommodation. In a survey of housing association tenants in England in which 2500 people were questioned, 65% of respondents were female, 43% were single person households, 65% were 65 years of age or over and 11% described themselves as 'black' (Lennox et al., 1991). In a similar survey in Scotland in which 1045 people were questioned, 61% of households were single person, 42% of lets were to single people or couples over 60 years old, 12% were to households with children and 0.3% were to households from a minority ethnic group (Wilson and Alexander, 1988). According to Housing Corporation statistics, nearly a third of households accommodated by associations in England in 1992 were considered to have previously been homeless (Housing Corporation, 1992). Of the 17% who were statutory homeless most were families with children but among the non-statutory homeless 60% were single adults (Housing Corporation, 1992).

Housing associations decide who to admit to their waiting list, how to determine priority and how to assign available housing unbound by any statutory duties. Consequently, differences in policy and practice arise from associations' differing aims and objectives (Spicker, 1991). As demand outweighs supply, access to the waiting list is usually determined by an assessment of 'need' weighed up against the objectives and focus of the association. The *selection process* determines whether an applicant is eligible and can join the waiting list. If deemed eligible, the

applicant then enters the *allocation process* which determines where in the queue they will be placed and what accommodation they will receive.

6.2.1 Approaching a housing association.

Twenty-two (22) respondents have approached a housing association for permanent housing since becoming homeless. Eighteen (18) respondents reported that they have not approached a housing association because they are unaware or unclear about housing associations, the accommodation they provide and how to apply. For example, two respondents reported that they have not applied because they think a down-payment of rent and deposit is required, one respondent believes that he is on a housing association waiting list automatically because he is living in a council hostel, four respondents do not want the supported accommodation they believe all housing associations offer and four respondents are unaware that housing associations exist. None of these 18 respondents has received any help or advice regarding the accommodation housing associations provide or how to apply. In contrast, all 22 respondents who have applied to an association did so after receiving help or advice regarding which associations to approach and how to apply.

Housing associations typically have a small stock with a low turnover of tenants.

Consequently, associations often have to limit demand by not advertising, restricting access to applicants referred from other agencies and by closing their lists to new applications. Not advertising means that potential applicants face difficulties identifying associations which they could apply to for housing (Institute of Housing, 1985). Associations who do not advertise rely on word of mouth to draw applications. This policy is likely to exclude many people, such as people from minority ethnic groups, people who have lived outside the area and people without support and advice (Spicker, 1991). Some associations, in particular those housing people with 'special needs', depend heavily on referrals from the statutory and voluntary sector (Spicker, 1991). Such rationing limits demand and cuts down administration but risks excluding people who have already been missed or excluded by other agencies. As a result, rather than housing people most in need, associations may end up housing people fortunate enough to apply through the right channels. Associations that close their lists usually do so for good reason - closed lists are easy to administer, it is not necessary to keep track of clients and people are not given false hope (Spicker, 1991). However, as Spicker (1991) points out,

closed lists have some major disadvantages. First, needs are relative and priority should be given to the greater need, but this cannot be judged when people are turned away without assessment. Second, it is difficult for a closed list to respond to urgent need and, third, it is difficult to gauge demand for housing and therefore plan future service provision when the level of need is not appreciated.

Twenty (20) respondents approached housing associations by submitting an application form, one respondent was referred and one respondent was nominated by the local authority. The one respondent who was referred is staying in temporary supported accommodation provided by a housing association. He was recently told by his support worker that after 11 months in supported accommodation he had been adjudged suitable for the association's permanent accommodation and his name had been referred to the lettings officer. The one respondent nominated by a local authority for permanent association housing is staying in a local authority managed hostel.

There is little research evidence on how local authorities use their nomination rights and on what basis they decide who to nominate to housing associations. Traditionally, the precise arrangements regarding nominations have been determined on a local basis but local authorities usually have the right to nominate people on their waiting list for at least 50% of all housing association vacancies (Parker et al., 1992). Parker et al. (1992) found that a third of local authority nominations to housing associations were homeless households and 22% were single adults, suggesting that local authority nominations may be an important route into housing association housing for single people (Anderson, 1994). Andy reported that he is uncertain why he has been nominated to a housing association but thinks it was because he was living in a particular hostel. Andy had applied and been accepted onto the waiting lists of four housing associations and had been on the council housing waiting list for two months when he moved into a council run hostel. Within two weeks of moving into the hostel he was nominated by the council to one of the housing associations that had accepted him onto their waiting list:

DR - What sort of time (on the waiting list) were they (housing associations) talking about?

ANDY - 12 months was average but then you also get council nominations. Funnily enough, the majority of them end up at 'hostel B'. If I had been in 'hostel A' I don't think I would of got the nomination for that flat with Edinvar (housing association) but because I was in 'hotel B' I did get a nomination.

DR - You got a nomination when you were in 'hostel B'?

ANDY - Yeah.

DR - Why?

ANDY - On the computer at 'hostel B' they put me forward for nominations which means that 50% of the housing associations in Edinburgh offer their property to Edinburgh District Council and they then nominate people for these housing association places. They nominated me for Edinvar whereas if I had been in 'hostel A' I can almost guarantee that I would not have got the nomination I did.

DR - So 'hostel B' is a good access point?

ANDY - Oh, most definitely.

ADC3

Nineteen(19) of the 20 respondents who approached a housing association by submitting an application form received help with their applications ranging from being given a list of associations in the local area and told to apply to as many as possible, through to advice on how to fill in an application form so as to maximise their chances of success. Fifteen (15) respondents were told about local housing associations but not about their objectives, the people they house and the accommodation they provide. Most of these 15 respondents, unaware that many associations only cater for a specific group of people, have applied to as many associations as possible. Five respondents got advice on which associations they would be best applying to given their circumstances and needs. Advised by hostel staff, advice centres, day centres and support workers, these five respondents have only applied to associations where they fall into the target group and have emphasised relevant circumstances, situations and needs on the application form. John is 33 years old and has been homeless five years. He reported that the advice he has received from a key worker in his hostel accommodation has been a great help when applying to housing associations, saving him from wasting time on applications that have no chance of success and ensuring that he targets associations where he satisfies eligibility criteria:

John - I got a list from my key worker, he keeps giving me addresses. That's pretty good, the key worker side. He tells me which (*housing association*) is a waste of time and which is better cause he has got the experience. That's what is good. If I get anywhere it will be down to my key worker cause there are places I'd go 'cause the council give you a list of other agencies but straight away he tells me which I can tick off. Some of them will get you on the files and that but they would only actually house four people. To sort out and to go there and register is £2 in bus fares.

PSP 2

To summarise, respondents who have received no help or advice about housing associations, the accommodation they provide and how to apply, have not approached any associations, respondents who have merely been given a list of associations in the local area have tended to

apply to as many associations as possible and respondents who have received guidance on which associations to apply to have only applied to housing associations where they have been told they have a chance of success in the selection process.

6.2.2 The selection process.

Twenty-two (22) respondents have applied to a housing association for permanent accommodation in an attempt to escape homelessness and re-enter the housing system. Two have been rejected by every association they have approached, six are still waiting to hear whether they have been accepted onto the waiting list and 14 have been rejected by at least one association and accepted onto a waiting list by at least one other association. Apart from one respondent who was told he was not accepted because of rent arrears with the local authority and two respondents who applied to associations which had closed their lists, respondents are unaware why they have been accepted or rejected. This is not surprising. Housing associations are under no obligation to justify their decisions and their selection and allocation procedures remain a black box system - all that is clear is what goes in and what comes out.

Housing associations have considerable autonomy when deciding who to accept onto their waiting list and can legitimately place restrictions on certain groups as a way of prioritising some, excluding others and limiting demand. In their study of management in social housing in England, Bines et al. (1993) found that 77% of housing associations place some form of restriction on their waiting lists which mean that an applicant is either excluded or deferred. The most common reason for exclusion from a list was having a history of rent arrears, followed by being deemed to be adequately housed, considered to have suitable alternatives and being below a certain age. Of the associations who applied an age limit, 81% restricted access to people aged under 18 years while other associations enforced limits ranging up to 55 years (Bines et al., 1993). Even if an applicant displays the needs that an association is aiming to satisfy and fulfils the eligibility criteria access is not guaranteed. Hill et al. (1992) report that of the 87 associations providing 'special needs' housing in England that they surveyed, 90% said that demand for special housing outstripped supply, and that being in 'need' and satisfying eligibility rules did not guarantee access to the waiting list.

All 22 respondents who have approached a housing association reported that the selection process involved completing an application form but only six respondents reported that they were interviewed by housing association staff before being informed if they had been accepted onto the waiting list. It is not clear why these six respondents were interviewed. One possibility is that they were interviewed by an association catering for a 'special needs' group and the interview was necessary to determine whether their needs matched the associations aims.

As well as questions about their current circumstances, personal history and accommodation wants and needs, all respondents were asked questions about their health, either on the application form or in an interview with association staff. The questions respondents were asked about their health vary from those solely about drug and alcohol use, through to being asked to list all their health and mobility problems and to discuss the impact of their health on their everyday life. Unlike the council housing service, housing associations have no statutory responsibility for people with health and mobility problems. However, what little evidence is available suggests that health and mobility problems can convey priority in the selection process for both general and 'special needs' housing. Hill et al. (1992) surveyed 93 housing associations in nine regions across England and looked at how associations accommodate health and mobility problems in the selection and allocation process. They found that access to 'special needs' housing designed specifically for people with health care and mobility needs is open to anyone with these needs, providing they satisfy the associations' other eligibility rules which are generally related to income and current housing status. Access to 'special needs' housing catering for other groups and general needs housing was found to depend on satisfying eligibility criteria linked to the associations aims, although if an applicant satisfied all such criteria health and mobility problems could convey priority in the selection process if demand outstripped supply. Associations rely heavily on an applicant's self assessment to collect information on health, a medical examination rarely being used and a GPs letter sometimes being relevant but rarely asked for (Hill et al., 1992).

In response to questions about their health, some respondents withheld information, thinking their health would hinder their application, some respondents only provided the information asked for on the application form or in the interview, while some respondents provided supporting evidence, such as a letter from a GP, in the hope that their health status would help

their application. Eight respondents withheld information on some or all of their health problems. When asked to explain why they withheld information, respondents either reported that their health would affect their chances of selection or that their health was not relevant or important to their application. The health problems these eight respondents have not mentioned include depression, lethargy, eating problems, sleeping problems, personality disorder, walking problems, asthma, scabies, a stomach ulcer, and problems with drug and alcohol use. Three respondents reported that alcohol or drug use is bound to disadvantage an application and so denied they were suffering from any such problem. Dan is 29 years old and is currently suffering from a problem with drug use, a back problem, lethargy, flashbacks, depression and eating problems. He reported that he did not mention his problem with drug use because it would disadvantage his application. He also failed to mention any of his other health problems:

DR - Did you tell them (the housing association) about your health?

DAN - No, I just waited for them to ask. I filled out the application form and it said do you do drugs and a few people told me to just miss it out 'cause if you put it down they knock you back straight away.

DR - Who told you that?

DAN- Just mates.

DR - Did you mention any of your other health problems (a back problem, lethargy, flashbacks, depression, eating problems)?

DAN- No, I just waited for them to ask.

DR - Was that the only question they asked you about your health?

DAN - Yeah.

ADC 9

It is not clear why some respondents think that their health is not important or relevant to their application, especially in light of evidence suggesting that health can convey priority in access to both special and general needs housing. However, it is perhaps significant that seven of the eight respondents who made no reference to their health in their application withheld information on mental health problems. It was reported in Chapter Three that many respondents have not sought medical help with mental health problems and I suggested that unwillingness to seek help could reflect the stigma attached to mental illness. The same reason could explain why respondents have not have mentioned their mental health problems when applying to housing associations. It is also worth noting that none of these eight respondents received any help or advice filling in their application form and were unaware that providing information about their health could help their application. Whatever the reason why they withheld information about their health, the result is that housing associations have assessed

their applications without full knowledge of their health status and medical needs. This finding is particularly worrying at a time when demand for social housing outstrips supply and priority is based on assessment of 'need'.

In contrast to the eight respondents who withheld information, six respondents answered all questions about their health and eight respondents sent supporting evidence of their health status along with their application. Seven of the eight sent a letter from their GP confirming their health status with each of their applications, either on the advice of hostel staff, a councillor, day centre worker or support worker who told them that doing so might help their application. One respondent sent a letter from her GP after being advised to do so by housing association staff. These respondents are unaware whether additional information about their health helped their application. All have been rejected by at least one association and accepted onto a waiting list by at least one other association. Since health and mobility problems can convey priority in the selection process in both special and general needs housing (Hill et al., 1992), it is likely that detailed information on health beyond that asked for in the general application form will not damage, and could improve chances of selection. If this is the case, applicants who receive help and advice have a distinct advantage in the selection process over people without guidance who might withhold information or fail to provide detailed supporting evidence from a health professional.

Twenty-two (22) respondents have applied to a housing association for permanent housing. Twenty (20) of these 22 respondents are suffering from health problems. It is not clear why some respondents have been rejected by all associations they have applied to and some have been rejected by some and accepted by others. Likely reasons for rejection are that respondents do not fit eligibility criteria, have applied to associations catering for a specific group to which they are not deemed to belong or that they are not regarded as being in sufficient need. Rejection for any of these reasons is justified by the fact that demand outstrips supply and housing has to be rationed. However, respondents experiences suggest that associations are rejecting some applicants unaware of their health and mobility needs.

6.2.3 The allocation process.

It is difficult to explain why respondents have or have not received an offer of permanent

accommodation. Housing associations are free to manage their waiting lists - determine priority and allocate housing - however they see fit, and are under no obligation to demonstrate consistency and impartiality. However, available evidence suggests that housing need and health factors are important to housing associations when determining priority and allocating housing. Hill et al. (1992) found that most associations organise their queue on some principal of housing need, and that medical priority, based on the actual or potential intersection of health problems with current and future housing environments, improves an applicant's opportunities above and beyond a range of other priority claims. The 14 respondents who have been accepted onto a housing association waiting list are all in severe housing need and 13 are suffering from health problems, including manic depression, personality problems, learning difficulties, anxiety and depression, lethargy, flashbacks, blackouts, eating problems, sleeping problems, musco-skeletal problems, scabies, walking problems and asthma. However, only three have been offered permanent housing. The other 11 have been on a housing association waiting list for over a year and are yet to receive an offer.

Four respondents have not been offered permanent housing because of their age, despite being in severe housing need and suffering from health problems, including personality problems, difficulties with alcohol and drug use, suicidal depression, lethargy, eating problems and scabies. All four are less than 21 years old. Although they passed basic eligibility criteria, they were told by association staff that they would not be offered permanent housing because they were too young. All four were instead offered temporary supported accommodation but only one accepted the offer. The other three insisted that they wanted permanent accommodation and were willing to wait. They are still waiting over a year after applying. The experiences of these younger respondents are no surprise. Bines et al. (1993) found that many housing associations impose an age limit that restricts access to younger people.

This still leaves unexplained why seven other respondents who have been accepted onto a housing association waiting list, are all over 21 years old, homeless and suffering from health problems have not been offered housing. There are two likely explanations. One possible explanation is that they are not judged to be in sufficient need. All seven mentioned that they are homeless in their application and most associations view housing need as important in determining priority (Hill et al., 1992). However, priority is awarded for many reasons, for

example, on the grounds of referral by a local authority, social services or the health service, waiting time, local connection, risk of violence, carers needing to move and decanting and clearance. Therefore, it is likely that homelessness alone is no guarantee of priority. However, all seven respondents are suffering from health problems and evidence suggests that health needs can convey priority above and beyond a range of other needs. So, why might respondents not have been awarded priority on the grounds of health? There are three likely explanations. First, three of the seven withheld information about their health from the housing association. There is no way an association can award priority on the grounds of health if it is unaware that an applicant is suffering from any health problems. Second, two of the seven are suffering from mental health problems. Hill et al. (1992) report that only one in six associations always award priority to people with learning difficulties and mental health problems. Third, the decision to award medical priority is typically taken by housing managers. Hill et al. (1992) found that although most associations often consult a health professional for help assessing and prioritising applications, the role of the health professional is usually limited to providing basic information and the decision to award medical priority is usually left to the discretion of a housing manager. Housing managers are unlikely to have any knowledge or skills in the health field and their prime concern is not fairness or consistency but managing demand for the association's housing stock. The only predictable outcome of this system is inconsistency in the awarding of priority, especially given that the most common allocation scheme used by housing associations for all their different lists (waiting, nominations, transfer and referral) is the merit or discretionary system (Bines et al., 1993). The advantage of merit schemes is that each applicants' individual needs can be assessed and taken into account. Their weakness is that consistency is difficult to achieve and impartiality impossible to demonstrate. Consequently, applications by two people in similar circumstances and with similar needs to the same housing association could result in different outcomes.

Another possible explanation for why seven respondents have been accepted onto a waiting list but not offered housing is because demand for housing association accommodation outstrips supply and even applicants in priority need cannot be guaranteed an offer of housing. During the last 20 years, housing associations have emerged as the politically favoured providers of social housing. However, the increase in housing association provision has not matched the decline in council housing. Between 1979 and 1989 1.3 million dwellings were lost from the council housing sector. During the same period housing association provision

increased by only 0.2 million dwellings. Housing associations have traditionally housed people on low incomes not considered to be the statutory responsibility of local authorities. However, the recent decline in council housing provision and the dramatic increase in homelessness has put pressure on associations to accept increasing numbers of nominations from local authorities (Harrison, 1992). Therefore, there are less units available for people not included in the statutory definition of homelessness and inevitably the needs of single homeless people are marginalised (Garside, 1993). It is, therefore, possible that priority need is no guarantee of an offer.

None of the respondents who are currently on a waiting list have any idea where they are on the list or how long they will have to wait for an offer. Bines et al. (1993) also found housing associations to be less than forthcoming with information to the applicant. Only 48% of associations routinely informed applicants of their position in the housing queue and less than half said that they told applicants the estimated time they would have to wait before an offer would be made (Bines et al., 1993). This point is of particular significance to homeless people. Homeless people are often living in unsanitary, unsafe and hazardous circumstances. They need to know how long they will have to wait for an offer so they know how long they will have to hold out in their present circumstances. Without this information homeless people cannot make an informed judgement about which associations to apply to. Consequently, some homeless people might not apply to associations even though they could be offered housing in a relatively short space of time, while some homeless people might waste their time applying to associations that will not offer them housing for years to come.

Three respondents have received an offer of permanent housing. All have accepted the offer and are waiting to move in. None of these three respondents is aware why they have been offered permanent housing. All three are living in temporary accommodation, one in supported accommodation for young people, one in a council hostel and one in a women's refuge. Only one of the three mentioned health problems in her application. Sandra is currently suffering from manic/suicidal depression and supplied a supporting letter from her GP with her application on the advice of a friend. Sandra has no idea why, after waiting for over a year, she has been offered housing. The other two respondents who have been offered permanent housing were referred to a housing association. One was an internal referral from an association's supported accommodation to their permanent housing department. The other

respondent is living in a council hostel and was referred by the local authority. Andy had applied to an association independently and was told that he could not be offered housing for at least 12 months. Subsequently, he was nominated by the council housing service to the same association and within two weeks he received an offer. Hill et al. (1992) also found that nominations from local authorities were often given priority.

6.2.4 Summary.

Eighteen (18) respondents have not applied to a housing association for housing either because they unaware or unclear about housing associations and the accommodation they provide. The 22 respondents who have applied to a housing association only did so after help and advice about where and how to apply. Fourteen (14) respondents have been accepted onto a housing association waiting list but only three have been offered permanent housing. It is difficult to understand why 11 respondents have not received an offer. All 11 are homeless and suffering from health problems, and available evidence suggests that health problems and housing need convey priority above and beyond a range of other factors in the housing association allocation process. Possible explanations are that respondents have not been recognised as being in priority need or that demand outstrips supply to the extent that priority need is no guarantee of an offer. Whatever the reason, the housing associations that respondents have approached have not been selective in favour of homeless people with health problems and the majority have been unable to escape homelessness and re-enter the housing system through the housing association sector.

6.3 Escaping Homelessness - Accessing Local Authority Housing.

In theory, people who are homeless and have health problems have high priority among people eligible for council housing (Shanks and Smith, 1992). Council housing would, therefore, appear to represent respondents' best chance of accessing permanent accommodation and escaping homelessness. However, need is no guarantee of success. Access to local authority housing is determined by the rules and procedures of local authority housing departments. These rules and procedures reflect influences from outside the local authority, in particular the size and quality of stock as determined by central government policy.

Following a period of expansion during the early post war years, when an attempt was made to provide good quality housing for all and to break the link between low income groups and poor housing, council housing has been declining in both relative and absolute terms. Over recent decades this decline has been actively encouraged by a government driven by the 'New Right' belief that welfare intervention is economically, politically and socially damaging, ineffective, inefficient and a threat to freedom. The restructuring of housing provision away from subsidised renting and towards subsidised home ownership has involved restrictions on new council house construction and the depletion of existing stock through the 'Right to Buy' initiative. Council housing has been reconstituted as a safety net tenure intended to counter the harmful effects of the housing market on financially weaker households - a residual service for households unable to survive in the market place. Access to council housing has always been based on some idea of 'need', but as the stock has declined and competition for council housing has increased, access has come to depend on satisfying some definition of priority need.

Demand for local authority housing outstrips supply and therefore has to be rationed. There is no national system for allocating public housing in Britain and each local authority is free to determine its own allocation policy (Foster, 1983). As a result numerous different management responses have been adopted to ration council housing. However, local authorities are required by law to recognise certain priorities, ensuring that emphasis is formally placed on equity and procedural fairness in allocations (Spicker, 1988). In particular, legislation gives certain homeless people the right to be rehoused by their local authority and conveys priority on applicants with medical needs.

Although different groups have been singled out to be awarded priority in the housing queue, homeless people are the only group given a statutory right to housing (Shanks and Smith, 1992). Under Part III of the Housing Act (1985) and the Housing (Scotland) Act (1987) a local authority has a statutory obligation to provide permanent housing if an applicant is homeless, in priority need and not intentionally homeless. People are defined as *homeless* if they have nowhere to live or if they are unable to access their home, if someone is living there who has been or will be violent to them, if it is not reasonable for them to live there, if they are living in emergency accommodation or if they will be homeless within 28 days. People are defined as *intentionally homeless* if they have done or failed to do anything that resulted in

their loss of home. People are defined as in *priority need* if they have dependent children, they are pregnant, became homeless in an emergency or are 'vulnerable' because of old age, illness, disability or some other special reason, which case law has established can include illness (Watchman and Robson, 1990). Therefore, in theory no sick people should be found among the long term homeless, and anyone with health needs in temporary accommodation should be quickly rehoused (Smith, 1991). A Code of Guidance intended to provide uniformity of interpretation and to soften the effects of amendments such as the intentionally provision was introduced to support the Act (Widdowson, 1987). However, under the Housing Act 1985 and the Housing (Scotland) Act 1987 local authorities are only obliged to 'have regard' to its guidance and at every level of implementation the Act is open to different interpretation by councils as to their duties and the principle of local discretion in the allocation of council housing remains strong.

As well as the accommodation of medical needs into the homeless legislation, there is also a well developed system of assigning priority according to medical need in the waiting and transfer lists. Medical need has long been influential in the allocation of housing in the 'public' sector. Throughout the 1950s and 1960s the council house stock grew and people disadvantaged by ill health had opportunity to rent at subsidised rates. In 1969 the Cullingworth Committee called for local authorities to target housing toward 'special social needs' and the importance among these of medical needs was confirmed in the 1970 Chronically Sick and Disabled Persons Act (Smith, 1990). During the 1970s, a wide range of medical conditions gave applicants some degree of priority access to council housing (Smith, 1989). However, the conditions worthy of priority and the degree of priority conveyed was left up to a council's own discretion. The only other statutory basis for medical priority is the provision made for people 'vulnerable' because of old age, illness, disability or some other special reason contained in the Housing Act 1985 and the Housing (Scotland) Act 1987. However, there is little consensus on what is meant by 'vulnerability' and local authorities assess and react to medical needs in different ways.

Two assumptions underlie the medical priority system; that an individual's housing needs are partly determined by the interaction between their current housing conditions and their health and that it is possible to weight this need against other determinants of housing need and the needs of other individuals (Connelly and Roderick, 1991). Based on information about an

applicant's health (which is collected on the general application form, on a medical self assessment form, in a letter from the applicant's GP, or through medical examination) a judgement is made, sometimes with the help of a health professional, on what priority to attach to an application on the grounds of medical need. There are essentially two routes out of the medical priority system. First, a minority of applicants are rehoused into 'special' schemes and, secondly, the majority are rehoused into the mainstream council rented stock (Smith, 1991). Although most authorities follow this basic procedure, no common practice exists on how to assign and weight medical priority and council housing departments discriminate between 'sick' and 'well' applicants in different ways.

The homelessness legislation and medical priority systems should mean that homeless people with health problems have high priority among people entitled to council housing. However, the statutory basis of these legal obligations is vague and ambiguous and gives authorities room for discretion. Discretion allows authorities to incorporate these statutory duties into their attempts to reduce and organise demand for council housing to manageable proportions. Reducing demand for council housing means applying various formal and informal techniques to ration the supply of housing and allows criteria other than need to influence dwelling allocation procedures. As a result, who gets housed and who gets what housing depends on who applies to a local authority for housing, how the authority determine who is eligible and how housing is allocated. These primary and secondary rationing systems incorporate rules and regulations passed down from central government, the aims and objectives of local housing managers and the discretionary decision making of housing officers and medical advisors. Therefore, who gets housed is not solely about 'need' but also about who can negotiate the obstacle course that is the council housing allocation system.

6.3.1 Approaching the council for permanent housing.

The first step toward accessing council housing is to apply to a local authority housing department. Twenty-five (25) of the 40 people interviewed in this study have applied for council housing in an attempt to escape homelessness and re-enter the housing system. Fifteen (15) respondents have not applied for council housing.

Reasons for not applying for council housing.

Although no formal eligibility rules exist to limit applications for council housing, given that the council housing stock has been ravaged by 15 years of 'Right to Buy' and the decline of the new build program, councils face increasing difficulty in providing adequate housing for the record numbers of homeless people. Consequently, rationing takes place at this early stage in the allocation process.

Informal or covert rationing - the deliberate or accidental withholding of information, deterrence, delay and dilution (Parker, 1975) - can restrict the number of applications. People cannot apply for a service that they do not know exists. Seven respondents reported that they have not applied for council housing because they do not know how to or because, contrary to the popular assumption that people in need are knowledgeable players of the welfare system, they do not know what accommodation is available. None of these seven respondents has received any help or advice about applying for council housing, all are unaware of the principal of medical priority and most are unaware that certain homeless people have priority among people eligible for council housing. All seven are suffering from health and mobility problems, including angina, bronchitis, urinary problems, diabetes, walking problems, learning difficulties, manic/suicidal depression and problems with alcohol use, four are in receipt of invalidity benefit, three have been homeless for over a year and six want to live in a flat or house of their own.

Deterrence can also limit applications for council housing. Deterrence prevents people making claims on scarce resources and often involves judgmental and stereotypical attitudes toward people seeking help (Lidstone, 1994). Foster (1983) argues that services for homeless people and unemployed people have always been provided in ways which are intended to deter the 'undeserving' claimants from seeking help. The roots of deterrence have been linked to the fear that better standards will encourage some people to use homelessness as a way to seek faster allocation of a council house (Parker, 1975), whereas poor standards ensure that only those in need will apply. However, poor standards can also deter people in need from applying. Three respondents reported that they have not applied for council housing because they do not want the kind of accommodation that the service has to offer. In particular, respondents referred to the poor condition of council dwellings and their unwillingness to live

on certain 'bad' estates. Michael is 54 years old and has been homeless two months. He is suffering from manic depression and is in receipt of invalidity benefit. Michael's last home was a council house which he left because of harassment. His experience of council accommodation is poor housing in undesirable areas. He has not approached the council for help because he does not want the housing he will be offered - difficult to let stock that no one else will accept:

MICHAEL - I had my own house in Glasgow, in fact I almost still have my own house in Glasgow, I've still got the keys for the door, but it was, it's been called the worst slum in Europe. I did two and a half years of it. there were bricks coming through the windows... Now, I do not want a house after that, after my experience of having a three bedroom house, having it practically set on fire, having yobbos coming with axes trying to break down the door, I'm entirely on my own, so I thought to hell with it. I gave away the furniture.... and I left and came here. I was also threaten you see by the drugs barons because part of the thing was that my garden was full of syringes you see? I didn't want to touch them. We do have such things as HIV positives and god knows what from these kind of things and of course this annoyed the drugs barons in the east end of Glasgow said I'd drawn attention to the fact that were drugs in the area and they were going to stitch me up. So, there's no point hanging around waiting to be stitched up. That's the kind of housing that Glasgow provides and it's also the kind of housing that Edinburgh provides for people in this position and I don't want to know it.
CDC1

Other reasons respondents reported for not applying for council housing are because they have been moving around and never settled anywhere, because they do not want a house and because they are already on a transfer list with a local authority (see Chapter Five).

Fifteen (15) respondents have not applied for council housing since becoming homeless or in the last five years. The vast majority have serious health problems and want their own flat or house but have not applied for council housing either because they are unaware or unclear about the council housing service or because they are deterred by the service they expect to receive. As a result, 15 respondents who, in theory, should have high priority among people entitled to council housing remain homeless.

Approaching the council housing service.

Twenty-five (25) respondents have applied for council housing. Six applied for council housing within days of becoming homeless and 19 were homeless between one month and five years before they applied. Asked why they did not apply earlier, respondents reported that they

either did not know how to apply or did not think the council could help them, and only applied after advice that it might be worth their while. When asked why they applied for council housing, most respondents reported that they want somewhere to stay and thought the council might be able to help. When asked what housing they were hoping for all reported they want a flat of their own. Only three respondents specified wanting a certain type of tenancy, two wanting a one bedroom flat and one wanting a ground floor flat because of mobility problems.

Eleven (11) respondents reported that they requested a flat in a certain area and will not accept offers in any other areas because of the poor quality of housing and the bad reputation of certain estates. Applicants for council housing often state a preference for an area or particular estate. Prescott-Clarke et al. (1994) found that only 11% of people on waiting lists in England said they would live anywhere in the council area and 55% said they would only live in certain area or particular estate. John reported that living in some areas would be as bad as being homeless and that he is willing to wait longer for a better offer:

DR - What were you hoping for when you approached the council?

JOHN - Just a flat... I don't want to wind up in a council estate full of idiots where every time you do something for yourself you get burgled or you get mugged or something... it could be just as bad stuck on a council estate if everyone is robbing you and nothing is safe and you are never going to get anywhere, as if you were here (in a hostel). I'm not trying to sound choosy. I am not bothered if it takes longer and more of my Giro for somewhere that is quite reasonable where I can leave my stuff, leave it there and know I can come back to it.

PSP 2

In order to join a local authority's waiting list all applicants have to fill in an application form. The information that applicants provide on this form is the basis on which a council assesses need and determines priority. There are no rules regarding what is asked on an application form and there are considerable differences between the information requested by different authorities. Prescott-Clarke et al. (1994) found that age is the only information requested by all local authorities in England, 98% enquired as to the relationship of the applicant to any other people applying to be housed with the applicant, more than half asked about employment details, previous council tenancies and current accommodation - number of bedrooms, type of accommodation, amenities shared or lacking - and less than half asked about length of time lived in the area, income details and ethnic origin. Most application forms also ask questions about the applicant's health. In a survey of the provision of council housing for people with

HIV and AIDS in Scotland, Grant (1995) found that all Scottish authorities ask something about health on their application form. However, the questions vary from yes or no questions about whether the applicant has any health problems, through to requests for the applicant to list all their current health and mobility problems.

All 25 respondents who have applied for council housing reported that there were questions about their personal circumstances, current accommodation and health status on the application form. All mentioned that they are homeless. However, only seven respondents answered questions about their health. This is a key finding that could help explain why homeless people with health problems who, in theory, have high priority among people eligible for council housing, are still homeless. Medical priority is based on an assessment of an applicant's health but the council housing service cannot assess need and award priority on the grounds of health (either medical priority or 'priority need' because of 'vulnerability') if they are unaware that an applicant has any health problems.

A finding that could explain why the majority of respondents who have applied for council housing did not answer questions on the application form about their health is the fact that on applying for council housing 16 respondents were unaware of the principal of medical priority, 11 were unaware that priority is given to certain homeless applicants and none knew on what grounds homeless applicants are recognised as being in 'priority need'. If people misunderstand the function of a service or do not know of its existence they are unlikely to apply (Parker, 1975). Smith et al. (1992) report that applicants rarely receive information about medical priority from housing departments. Fourteen (14) of the 16 respondents who were unaware of the principal of medical priority when they applied to the council housing service mentioned none of their health problems on the application form. The problems these respondents did not report include respiratory problems, musco-skeletal problems, genito-urinary problems, manic/suicidal depression, problems with alcohol and drug use, paranoia, flashbacks, lethargy, eating problems and sleeping problems. Asked why they had not mentioned their health problems, seven respondents reported that their health was irrelevant to their application and the housing department had no right to know, two respondents reported that they did not want to mention problems with drug or alcohol use because it might effect their chances of success and three reported that their problems were not serious enough to mention. Four respondents who were aware of the principal of medical priority when they

filled in their application form also withheld information about their health. Three reported that they thought that if the council was aware of their mental health problems it could damage their chances of success and one respondent reported that he thought an applicant had to be 'disabled' in some way to get medical priority and so saw no point mentioning his mental health problems. Therefore, in total 18 respondents did not mention their health problems on their application form because they were unaware or unclear about the principal of medical priority.

Seven respondents revealed their full health status when they applied for council housing. Five of the seven were aware of the principal of priority on health grounds and two received help filling in their application form. Both were told by hostel staff that they should mention all their health problems on the application form because doing so could help their application. Three of the seven sent a letter from their GP along with their application without it being requested, two on advice, one independently and all because they thought it would help their application.

Summary.

Whether or not a respondent has applied for council housing seems to rest on whether or not they know how to apply. Fifteen (15) respondents have not applied for council housing because they are unclear about the council housing service, who it serves and how to apply. Nineteen (19) of the 25 respondents who have applied for council housing only did so after being told how to apply and that the council might help them. Six respondents were aware of the council housing service and how to apply when they became homeless and all applied for council housing immediately on becoming homeless.

Whether or not a respondent mentioned their health problems on their application form seems to depend on whether they knew priority is awarded on the grounds of poor health or were advised that mentioning their health problems might help their application. Eighteen (18) of the 25 respondents who have applied for council housing did not mention their health problems on the application form. All were unaware or unclear about the principal of medical priority. Seven respondents answered questions about their health on the application form. All

seven were either aware of the principal of medical priority or advised to mention their health problems.

The experiences of these 40 respondents challenge the comfortable assumption that if a person needs the help of a service they will find out about it. Contrary to the stereotype that people in need are knowledgeable players of the welfare system, the majority of respondents are unaware of how to play the council housing system to their advantage and have failed to provide information about their health that could have helped their application.

6.3.2 Selection of applicants and access to the waiting list.

On receiving an application, the council has to decide whether an applicant's name should be put on the waiting list. Some authorities operate an open waiting list and admit anyone who applies. Other authorities restrict access to their waiting list by devising eligibility criteria which stop people from taking the first step in the allocation process (Foster, 1983).

Local authorities are under general instruction to accept large families, people living in overcrowded and unsanitary conditions, people in unsatisfactory housing conditions and certain homeless people as defined in Part III of the Housing Act (1985) and the Housing (Scotland) Act (1987). Authorities are not allowed to enforce a minimum age requirement over 18 years of age or a residential qualification if the applicant is employed in the local authority, looking for or offered employment in the local authority, has a social or medical reason to be in the local authority or is over 60 years old and moving to be near a younger relative. However, local authorities can still restrict access to housing waiting lists. Available evidence suggests that restrictions are based on personal circumstances, for example age, marital status and current accommodation, or on the basis of assumptions about an applicant being a problem tenant, for example, because of rent arrears or a history of 'unsociable behaviour'. A survey conducted by the Institute of Housing (1990) found that 80% of local authorities impose some eligibility rules on waiting list applications. Applicants most commonly refused or deferred include single people without children, people under 18 years old, people with rent arrears, people living in owner occupation and people deemed to be satisfactorily housed. In a study of local authority housing policies and single people, Venn (1985) found that 80% of local authorities operate restrictions which limit the opportunities of

single people to register on a council housing waiting list, for example, by age and a minimum local resident requirement. In a study of access to social housing in Scotland, Spicker (1991) found that where restrictions do exist they are linked to people seen as a problem for housing managers and other tenants.

Three of the 25 respondents who have applied for council housing in an attempt to escape homelessness have not been allowed onto a waiting list. Harry and Chris were told that they will not be considered for housing because of rent arrears from a previous local authority tenancy. Jo is not clear why her application was rejected.

Harry is 50 years old and has been homeless over 10 years. For most of this time he has lived in the same dormitory hostel in central Edinburgh. Harry is suffering from schizophrenia. He was aware of the medical priority system when he filled out his application form and mentioned his schizophrenia and provided a supporting letter from his GP on request from the council. Harry is unsure if he was recognised as homeless because the hostel has no restriction on length of stay and is viewed by the council as permanent accommodation. After an interview with a council housing officer, Harry was told he would not be considered for council housing until rent arrears of £900 were paid in full. Harry told the council that the arrears were run up by his ex-wife after he had left the flat they used to share but the council still refused to help. Harry is unable to work, is on invalidity benefit and has no way of paying off the £900 debt. Since applying to the council two years ago he has not looked for alternative permanent housing.

Chris is 22 years old and has been homeless three months. Chris applied for council housing after being encouraged to do so by staff at a hostel. When completing the application form she referred to her personal circumstances and why she had left home. However, Chris was not aware of the medical priority system and did not mention the depression she had been suffering from for a number of months because 'it didn't seem relevant'. Soon after applying Chris was told that she would not be considered for housing until she cleared rent arrears that she incurred when living in a council tenancy with her ex-partner four years previous. Chris is unemployed and has no way of paying off the debt.

Jo is 20 years old and has been homeless six months. On becoming homeless Jo applied to the council for a joint tenancy with her partner. Jo was unaware of the medical priority system when she applied. On the application form she mentioned she was suffering from severe abdominal pains but did not refer to the depression and severe headaches she was also experiencing. She explained to the council that she had left home after a disagreement with her parents and did not feel she could go back. Soon after applying, Jo and her partner received a letter from the council telling them that they would not be considered for housing. Jo does not know why they were rejected from the waiting list. Subsequently, Jo has split from her partner but has not reapplied to the council because she assumes her application will be rejected.

These three respondents are all homeless and suffering from health problems. However, they have been denied access to council housing because they fail eligibility criteria. Therefore, in total 18 out of 40 respondents have not been accepted onto a council house waiting list for reasons unrelated to their needs - lack of knowledge, misunderstanding, deterrence, delay and failure to meet eligibility criteria. Two respondents have applied to the council but are yet to hear if they have been accepted onto a waiting list. Therefore, only 20 out of 40 respondents have been accepted onto a council house waiting list.

6.3.3 Priority need and the allocation of housing.

Applicants who successfully pass through the eligibility filters that remove certain groups from the allocation process join a queue of applicants waiting to be housed - the waiting list. In doing so they enter another rationing exercise which determines the priority given to each application (Foster, 1983). Local authorities use waiting lists as a mechanism for prioritising applicants and allocating housing. Free to exercise discretion, different local authorities manage their waiting lists in different ways.

Prescott-Clarke et al. (1994) found that nearly three quarters of authorities in England divide their waiting list into distinct groups or queues. This often involves certain groups being treated as distinctive from the general needs waiting list. These distinctive groups often reflect priority groups or people queuing for particular housing. The most common group to be treated separate from the waiting list are homeless applicants (Prescott-Clarke et al., 1994). As well as treating certain groups as distinctive, most authorities also assign priority between

groups and all assign priority within groups. Prescott-Clarke et al. (1992) found that in England 80% of authorities use a points scheme to determine priority and Spicker (1991) found that 35 out of 45 local authorities in Scotland use point schemes to determine priority between applicants. Point systems are favoured over the use of discretion or date order schemes because they are viewed as impartial, fair, consistent and capable of including a number of factors, but they are open to organised bias and the awarding of points is open to discretion (Spicker, 1991). However, regardless of how local authorities manage their waiting list, they have a legal obligation to prioritise applicants in medical need and applicants who are homeless, and for this reason homeless people with health problems have high priority among people eligible for council housing.

Priority on the grounds of poor health.

Local authorities have a statutory duty to homeless people who are 'vulnerable' due to 'old age', 'mental illness or handicap', 'physical disability', or 'other special reason', which case law has established includes illness, and there is a well developed system for awarding priority to people recognised as having medical and mobility needs. In theory, information on an applicants health and mobility problems is collected, assessed and priority awarded if an applicant is deemed eligible.

All 20 respondents accepted onto a council housing waiting list were interviewed by a housing officer after they had submitted their application. This interview represented a chance for the housing department to confirm the details of the application, collect further information and inform respondents about the allocation process. By using the interview to help respondents understand why they are being asked about their health - by explaining the medical priority system and the priority given to homeless people - the council housing service could have encouraged respondents to talk about their health and ensured that their needs were identified. However, few respondents learnt anything about the council housing service from their interview with a housing officer.

Ten (10) out of 20 respondents were still unaware of the principal of medical priority after their meeting with housing department staff, four were told about medical priority but were still unaware how priority is determined and all respondents were still unaware on what

grounds homeless people are deemed to be in 'priority need'. Consequently, these 10 respondents still saw no reason to tell the council housing service about their health. For example, Gerry is 57 years old and is suffering from a chronic back problem, depression and sleeping problems. He is unable to work because of his back problems and is in receipt of invalidity benefit. Gerry has applied for council housing on two separate occasions since becoming homeless and is still unclear about medical priority. When he first applied for council housing Gerry said nothing about his health on the application form and was told nothing about medical priority in his interview with housing staff. A number of years later Gerry reapplied for council housing on the advice of hostel staff. Again he said nothing about his health on the application form and was told nothing about medical priority in his interview with housing staff. Subsequently, he received an offer which he refused because he was unhappy with the estate and the condition of the flat. As a result he was called in for another interview with housing staff and it was only then that the council advised him to get a letter from his GP. However, Gerry thought the whole process too complicated, was not sure if he would qualify and so decided not to bother:

DR - When you approached the council (for a second time) did they ask you any questions about your health?

GERRY - As I got further on they interviewed me, the first interview about the furnished accommodation. When the girl was giving me a form for that she asked me about my income and I showed her the thing from work about ill health and she suggested trying for medical points but I didn't think that was qualified and it would of been long term.

DR - That was after....

GERRY - I had had the first offer and when I started talking about furnished accommodation.

DR - Did you know about the medical points system before?

GERRY - No.

DR - What did she say about it?

GERRY - Well, she gave me a form and although my doctor had got me down as chronic back problem the different illnesses on the form didn't seem to apply to that. I think she still felt that I should of filled it in 'cause I had a long term sick line. I felt I didn't want to go down that road.

DR - Why not?

GERRY - Well, my doctor is in Glasgow. To me it looked all complicated. I'll tell you another reason, see how I got fed up with that first offer, I was considering forgetting about the council and trying to save up money for private accommodation.

DR - Did you tell the woman at the council the health problems that you have got?

GERRY - I didn't mention the depression, I did mention the history of my back and how I had a long term line. She thinks I should of filled in the form. When I knocked back the second offer she sent me the form for my health put I left it.

DR - Do you think it would have helped you if you had filled in that form?

GERRY - I don't know, it would of been long term.

DR - Would it of given you some more points?

GERRY - I think the girl thought that but I don't know 'cause the things they put down on the form it seemed you had to be in a situation where you couldn't walk, I didn't feel. I think the way she spoke I might of got something out of it.
ADC 12

As well as not informing respondents about the principal of medical priority and the council's statutory duty to homeless applicants, few housing officers took the opportunity of the interview to collect or confirm information on respondents' health. Fifteen (15) of the 20 respondents accepted onto a council housing waiting list did not tell the council about their health in their application. Eight of the 15 were not asked about their health when interviewed by housing staff and the other seven were asked about their health but continued to withhold information unaware that telling the council about their health might help their application. Three of these seven respondents were afraid of how the council would react if aware they had a problem with drug use and four did not believe their mental health problems were relevant or legitimate. For example, Lizzie is 23 years old and is suffering from eating problems, sleeping problems and depression. Lizzie is aware of the principle of medical priority but is unsure on what grounds priority is awarded. She has not mentioned any of her health problems to the council housing service:

DR - Did they ask you any questions about your health when you applied to the council?

LIZZIE - Yeah, on the form. You get extra points. Everyone keeps telling me it's a shame you are not ill, you get extra points.

DR - You know about medical priority?

LIZZIE - Oh yeah.

DR - Did you say that you had any health problems on the form?

LIZZIE - Nothing.

DR - You didn't mention your insomnia, eating problems or depression?

LIZZIE - No, I didn't think that you could put things like that, can you? They take more into account like terminal cases.

CST 3

The three respondents who referred to all their health in their application and provided supporting medical evidence were asked no further questions about their health in their interview with a housing officer. One of the two respondents who mentioned their health problems in their application but provided no supporting evidence reported that she was suffering from epilepsy and was asked to fill in a self assessment form to be signed by her GP. The other respondent who mentioned her health problems on the application form but provided no supporting evidence reported that she was suffering from severe depression, exhaustion and musco-skeletal problems and was merely asked if the information on her application was

correct. Therefore, the council housing service is only aware of the health and mobility needs of five of the 20 respondents who have been accepted onto a waiting list.

The failure of housing officers to inform respondents about medical priority and the council's statutory duty to homeless applicants could reflect the skill, competence, experience and time housing officers are able to put into a case. It could also reflect the need for officers to withhold information from applicants in order to limit demand for a service already over-stretched and under-resourced. Research evidence suggests that demand for access to council housing on the grounds of medical priority is high and rising (Smith, 1990). Prescott-Clarke et al. (1994) found that 22% of applicants to local authorities in England had a medical condition or disability that made it necessary to move to new accommodation. Alternatively, housing officers might be aware that homeless applicants stand little chance of being awarded priority on health grounds and therefore see no point advising applicants about medical priority or collecting information on their health. In their case studies of housing provision for people with health problems in nine English local authorities, Smith et al. (1992) found that homeless people do not always have access to the medical priority system. Applicants accepted as statutorily homeless often queue for different parts of the housing stock to applicants awarded medical priority and an applicant can only be in one queue. Therefore, an applicant can either be sick or homeless but not both. The reason why homeless people often queue separate from other applicants is because if their priority was translated into allocation policy some authorities would have to use all their vacancies to house homeless applicants. By making homeless applicants queue separately, by limiting offers to homeless people to certain stock (usually difficult to let housing), by allowing homeless people less refusals than other applicants and by regulating demand by using temporary accommodation, authorities can deter applications through poor standards and release new tenancies for other applicants, including those awarded medical priority (Smith et al., 1992). Thus, despite a well developed system for awarding priority to people recognised as having medical and mobility needs, homeless people with health problems are not always considered for priority on health grounds.

Homeless applicants who are denied access to the medical priority system can, in theory, get priority on health grounds if they are deemed 'vulnerable' because of health and mobility needs as defined in the homeless legislation. However, Smith et al. (1992) found that local

authorities are not as rigorous or formalised in assessing an applicants health when establishing 'vulnerability' as when establishing medical priority. Local authorities find the issue of vulnerability and priority need one of the most difficult aspects of the homeless legislation to put into practice. In particular, authorities report that it is difficult to know what kind and extent of mental and physical health and social problems constitute 'vulnerability' (Niner, 1989). Many authorities have no formalised procedures to ensure that homeless applicants health problems are recognised and none have formalised procedures to ensure they are dealt with fairly and consistently (Smith et al., 1992). Consequently, although 'vulnerability' has been defined in law as including people 'vulnerable' due to 'old age', 'mental illness or handicap', 'physical disability' or having any 'other special reason', which case law has established can include a wide range of health problems, homeless people with medical needs are not always recognised as 'vulnerable' and are not given high priority among people queuing for council housing.

Housing officers, aware that few homeless applicants are considered for priority on health grounds, have little reason to ask homeless people about their health or tell them about the principle of medical priority. At the same time, unaware or unclear about the principal of medical priority, applicants may see no reason to answer questions about their health. Consequently, the council housing service is unaware of the health status of 15 of the 20 respondents accepted on a council housing waiting list. This is an important finding. The implicit aim of medical priority rehousing is to take account of medical need when awarding priority for rehousing (Connelly and Roderick, 1991). The experiences of these respondents suggest that this aim is not being fulfilled.

Assessment of medical need - Five respondents mentioned their health status to the housing service. All reported that they were aware or had been advised by hostel or advice centre staff that the quality and quantity of information provided about their health could influence the outcome of their application. All five submitted supporting evidence of their health status. Three sent a letter from their GP with their application. One respondent completed a self assessment form on the request of housing staff which was signed by her GP and one respondent supplied a letter from her GP one year after first applying, after being told by a friend that doing so could help her application. Having mobilised the medical priority system, the outcome of these five respondents' applications is dependent on a complex bargaining

procedure between housing officers, whose prime concern is managing the stock, and health advisors, whose prime concern is identifying need.

Local authorities incorporate medical advisors into the medical priority process in different ways. Smith et al. (1992) identified three general management models; farmed-out systems wherein medical officers have complete authority for assessing and awarding priority; in-house systems in which housing officers have authority for awarding medical priority but might consult a medical officer for advice; and a combination of the two where medical and housing officers together assess applications and award priority. In Scotland, all local authorities use farmed-out systems (Grant, 1995). However, housing officers can still substantially effect the outcome of medical assessment and regulate demand by their comments, different levels of effort, efficiency and how they incorporate medical priority into the allocation process (Smith, 1990).

Two fundamental problems inherent in the system for assessing and awarding medical priority for rehousing mean that inconsistencies are inevitable (Smith, 1989). First, medical professionals have no formal guidelines as to what constitutes a housing related problem and, therefore, have no basis for assigning priority. They also know little about the housing system, available stock and the allocation process and can make unrealistic demands regarding priority for housing (Smith et al., 1992). There are few guidelines on how to grade medical priority probably because it is a logical impossibility to rank disease against disease, medical need against medical need (Smith, 1989). For example, how can the needs of an applicant with bronchitis be graded against an applicant suffering from depression (Muir Gray and Yarnell, 1979)? Consequently, the system is dependent on the discretion of medical advisors, but reliance on discretion makes conformity in decision making impossible.

The second fundamental problem that produces inconsistency is that that problems with medical recommendations are compounded when they are fed back into the housing bureaucracy (Smith, 1989). The amount of priority given to an applicant in medical priority depends on how the local authority incorporates medical need into housing allocation. Some authorities have separate medical queues, some give a single fixed amount of points to everyone in medical priority and some authorities grade medical priority so as to reflect the severity of problems and need (Smith et al., 1992). The idea behind grading is that applicants

in most need move fastest up the queue while others do at least get some priority. However, housing professionals are not trained to assess medical information and there are few guidelines for incorporating medical recommendations into the allocation process (Smith, 1989). It is, therefore, questionable to what extent housing officers are able to take account of medical recommendations and make judgements based on need.

Once priority on health grounds has been established the length of time an applicant will have to wait for housing will depend on their overall priority within the allocation process which, in turn, depends on the weight assigned to medical priority, whether they are a new applicant and the extent of homelessness in the local authority (Smith et al., 1992). The weight attached to medical priority varies between authorities. For example, Thomas and Yarnell (1978) found that in Wales medical priority can contribute between 13% and 67% of the total points required for rehousing, in Oldham it can contribute up to 50% (Gardner and Troop, 1981), in Portsmouth up to 40% (Howells, 1984), in Oxford little at all (Muir Gray, 1978) and the CRE (1984b) found that in Hackney medical priority can contribute up to 25 points, 15 more than for any other reason. Whether a person is a new applicant or a transfer applicant can affect the time they have to wait for housing because as a result of direct and indirect discrimination transfer applicants can receive higher priority and faster housing than new applicants (Smith et al., 1992). The extent of homelessness in a local authority affects the overall priority of an applicant with medical priority because people who are officially homeless have the highest priority in the housing queue, and the more officially homeless applicants the more people with greater priority than applicants with medical needs. However, local authorities can achieve a better outcome for medical priority applicants than homeless applicants by fast tracking urgent cases and preventing homeless people from competing for the same properties as other applicants (Smith et al., 1992). As a result, an applicant awarded medical priority might be housed quicker than an applicant recognised as officially homeless. The median number of years on the waiting list for statutorily homeless applicants in Prescott-Clarke et al.'s (1994) study was 0.7 years compared to 0.6 years for applicants awarded medical priority.

Demand for rehousing on health grounds is high but the proportion of tenants housed for medical reasons is small. Prescott-Clarke et al. (1994) found that 21% of waiting list applicants in England claimed to have medical needs but only 3% of new tenants in had been

rehoused because of medical need. In Tower Hamlets between January 1983 and May 1984 medical reasons only accounted for 2% of offers to Asian households and 8.8% to others (Phillips, 1986) and in Liverpool between 1977 and 1981 medical reasons only accounted for 4% of applicants housed (CREa, 1984a). In this study, five out of 20 respondents who were accepted onto a council house waiting list supplied evidence of their health problems but only two has been awarded medical priority. Nicky has learning difficulties and is suffering from depression. She was not registered with a GP in the local area but hostel staff arranged for her to see a GP at a local medical centre so she could send a supporting letter with her application. Nicky was told within a month of making her application that she had got extra points for health reasons and has since been offered a flat which she has accepted. Tony is on invalidity benefit and suffers from blackouts, sleeping problems and has problems walking. He mentioned all his health problems on his application, sent a supporting letter from his GP on the advice of hostel staff and requested a ground floor flat because of problems getting up stairs. Within two months Tony received an offer of a fourth floor flat. He was unable to accept the offer because of his mobility problems. Soon after refusing the offer he moved out of the hostel from where he had made his application but did not inform the council of his change of address because he had given hope of the them offering him suitable accommodation.

It is unusual for an applicant's health to be assessed and priority awarded as quickly as it was in Nicky and Tony's case. Three respondents are still waiting to hear if they have been awarded priority on grounds of their health. Cathy is suffering from manic depression and has been waiting five months for her application to be processed, Sandra is suffering from suicidal depression, exhaustion and aching joints and muscles and has been waiting six months and Pat is suffering from epilepsy and has been waiting one month.

Priority on the grounds of homelessness.

Single homeless people with health problems who are not awarded priority on the grounds of health can still be given priority in the housing queue if they are recognised as homeless and in 'priority need'.

Ten (10) respondents have been recognised as either having nowhere to live, unable to access their home, living in emergency accommodation or likely to be homeless within 28 days and therefore officially homeless. Five respondents are unaware whether they have been recognised as homeless and five respondents reported that the council did not recognise them as officially homeless. Four of the five who have not been recognised as officially homeless reported that they were living in a dormitory hostel which has no set period of tenancy when they applied for council housing and were told by housing staff that they were living in permanent accommodation and, therefore, not homeless. The other respondent who has not been recognised as officially homeless has not informed the council about her current circumstances. Cathy applied to the council when she was living with her ex-partner. Since applying she has moved in with relatives. Aware that she will not be recognised as homeless and will get less points living with relatives than sleeping on the floor in a cramped one bedroom flat with her ex-partner, Cathy decided not to mention her change in circumstances to the council. Cathy is the only respondent with any detailed knowledge of the council housing allocation process and the priority given to homeless people. Armed with this knowledge she has tried to maximise her chances of success in the allocation procedure. However, five months after applying she is yet to receive an offer.

Homelessness and priority need - Applicants who are recognised as homeless are only given priority if they are also judged to be in 'priority need' under the terms of the homeless legislation. However, few single people are accepted as being in 'priority need'. In their study of local authority policy and practice on homelessness, Evans and Duncan (1988) found that 80% of households accepted as homeless included children or pregnant women and Prescott-Clarke et al. (1994) report that only 14% of new tenants in England who have been recognised as statutorily homeless are single people with no dependent children. Only four respondents in this study reported that they have been recognised as in 'priority need' under the homeless legislation

The reason so few single people are recognised as being in 'priority need' is because unless they are pregnant or are homeless as a result of an emergency such as fire or flood, the only chance they have of being recognised as 'vulnerable' is for 'other special reasons'. Local authorities in Evans and Duncan's (1988) study reported that defining priority need was fairly straightforward except for decisions on 'vulnerability' for 'other special reasons'. Lloyd et al.

(1994) surveyed the management of homelessness in 274 English local authorities and report that the most frequent complaint made by senior housing officers was regarding the defining of priority need and the excluding of single people and couples without children. Only 24% of authorities reported that they regard people sleeping rough as in priority need, only 50% regard people living in hostel accommodation, squatting or living in bed and breakfast as in priority need and only 75% regard people living in unfit accommodation as in priority need (Lloyd et al., 1994).

Applicants sometimes considered as 'vulnerable' for 'other special reasons' include women at risk of violence, young people at risk of sexual or financial exploitation, care leavers, people discharged from institutions and people who have been in prison, but there still remains no clear consensus on what constitutes 'vulnerable' (Anderson, 1994). For example, Niner (1989) identified variable treatment for women escaping violence when examining homelessness policy and practice in nine local authorities in England and Wales. Five authorities automatically gave women escaping violence priority, one authority often awarded priority but not automatically, two were unlikely to award priority and one would not accept women escaping violence as in 'priority need'. Three respondents, all women, left their last home because of violence from their partner. All three told the council the circumstances under which they had left home. One respondent was able to back up her claims with evidence from the police. The council recognised that she was in 'priority need' and she has received an offer of permanent accommodation. The other two respondents who left home following violence from their partner were unable to provide any supplementary evidence and have not been given priority.

Inconsistency in the awarding of priority because of 'vulnerability' for 'other special reasons' is also evident in the treatment of young people. Recent research on local authorities' response to young homeless people has found that young people are often not considered a priority merely because of age, even when less than 18 years old. Thornton (1990) found that about 40% of local authorities in England would only accept young people to be in priority need if they qualified under criteria other than age. Caskie (1993) found that in Scotland, only 40% of authorities accept homeless young people aged 16 or 17 years old as vulnerable on account of age alone and very few extend this provision to people aged between 18 and 24 years old. The introduction of the Children Act (1989) has placed further duties on local authorities with

regard to young people. Under the Act, young people aged between 16 and 21 may be considered 'children in need' and the local authority may have a duty to house them (Anderson, 1994). Under the act, young people may be considered in need if they are considered unlikely to be able to achieve or maintain a reasonable standard of health or development without the help of the authority, if their health or development is likely to be impaired or if they have a disability. However, preliminary studies of authorities' working of the act suggest uncertainty over implementation and question whether local authorities have the resources to fulfil their obligations to young people (Goldman, 1992; McLuskey, 1993; Strathdee, 1993). Five respondents were less than 18 years old when they applied for council housing. Three reported that they were recognised as 'vulnerable' and in priority need because of their age. All three were offered a flat within a month of applying. However, one respondent who was less than 18 years old when he applied reported that he has not been recognised as 'vulnerable'. Seven respondents were aged between 18 and 24 when they applied for council housing. None were given priority on grounds of their age.

The offer of council housing - Ten (10) of the 18 respondents who have not been awarded priority on grounds of their health reported that they have been offered council housing. Three respondents reported that they were offered housing because of their age (all three were less than 18 years old) and one respondent reported that she was offered housing because she had left home to escape a violent partner. The six other respondents who have received an offer are unsure why they have been offered council housing but reported that they were awarded points for being homeless, even though they were not recognised as being in a priority group. Awarding points to applicants who are homeless but not in 'priority need' is not uncommon practice. Prescott-Clarke et al. (1992) found that 33% of local authorities in England award points to homeless people on the general waiting list. However, these points alone will not be sufficient to secure an offer.

Two respondents have been offered housing and are waiting to move in. The other eight have either accepted an offer and moved in and out again shortly afterwards or refused the offers they have received. All three respondents who have been recognised as 'vulnerable' because of their age have been offered council housing but are still homeless. Cameron was 17 years old when he applied for council housing. He was offered a flat within two months of applying and moved in soon after. However, Cameron had never lived on his own before and was unaware

of the practical and financial responsibilities of being a tenant. Consequently, without any help or advice he did not know to arrange rent payment with the Housing Benefit department and soon ran up large rent arrears. Not knowing how to cope he left the flat and terminated the tenancy. Cameron has not since applied for council housing after being told by housing staff that he is ineligible because of rent arrears. The other two respondents who have been recognised as 'vulnerable' because of their age have refused the tenancies they have been offered by the council. Gill is suffering from alcohol dependency and suicidal depression. She reported that on being offered a flat in an out of town estate she did not feel she would be able to cope in a flat on her own in an area she did not know. Subsequently, Gill moved in with relatives. Lesley reported that she refused the council's offer because the flat was in such bad condition. She soon received another offer with which she was similarly unimpressed and has given up any hope of escaping homelessness with the help of the council:

LESLEY - They said that they would be able to give me a house but with you being homeless and that and with you wanting it short notice it'll be a place in all these horrible places like Niddrie and Granton. So you tell them that you have got somewhere to stay for a couple of weeks so that you can get a decent place and tell them that you're loony living in a place like Granton cause you living on your own and they'll try and get you something that's reasonable.

DR - So, they offered you accommodation straight away out in Granton but they said that if you didn't want that you could get somewhere temporary and wait for a decent...

LESLEY - They told me that I would be offered two houses and put on a list. They offered me one house but I wouldn't take it. She (friend's mother) was appalled by it. They even got pictures of it in the Evening News (local paper). It was totally appalling, unliveable, horrible. It was a mess, it was mad. I had another appointment with them to explain why I didn't want it. I told them that I would be living on my own and it was a ground flat and anything could get carried. So I told them. I got a letter saying that I had to go and see them and I got another letter in the second post saying that they had another house for me. I went to see them and they sent me to [a hostel] from there. They said that I had to go straight there for an appointment so I went straight there and the place seemed a lot better than the house they had shown me and they asked me if I could move in and I said like a week later. So, I stayed with my friend for another week and then I moved in there.

BDR 1

In total, seven respondents reported that they have refused an offer because of the location and condition of the house or flat. Six of the seven did not specify a preference for any particular area on their application form but were so dissatisfied when they viewed the property that they refused the offer in the hope that the next offer would be something better. Sandra did specify a preference for certain areas on her application form. However, she reported that she was told by a housing officer that she does not have enough points to be housed in any of the areas she

requested and has come to the conclusion that homeless applicants will only be offered housing in certain areas:

SANDRA - What annoyed me was they started from the beginning and gave me this form to fill in that gives you all the different areas and you tick them so I did that and they send you a house in West Granton that you have no ticked off. I said what was the point of this form to start with, a waste of money, a waste of time, a waste of both times. You know what I mean? They have already got their decision. Can they not just say, look you are homeless go there rather than go through the whole thing and giving people more problems, not knowing, and they have already got a different system decided. That was what annoyed me. They had two different systems to make you think that you have got rights and the other, there is really a system behind that they have got for you 'cause you are homeless, you are at the bottom of the pile so you get the bottom of the pile house. So why go through all that?
SFD 1

Lizzie reported that she received an offer within two weeks of submitting her application but is unsure why. She was unhappy with the area in which the flat was located and so refused the offer. Lizzie reported that after she refused the offer pressure was put on her by housing officers who said it was unlikely she would be offered anything better and should accept the offer if she really needs housing:

LIZZIE - I got a bit depressed when I went to see that flat and I sat in it. It was absolutely gorgeous and so much could of been done with it but it was in such a grotty area. I went back to say I wasn't going to take it 'cause I felt very insecure. It was an absolutely vile place.
DR - What did they say?
LIZZIE - He kept trying to persuade me to take it in a way. He was saying he had no idea what waiting list I would be on and I presume if you are homeless that it will be urgent, so if you are really homeless and it is urgent why don't you take it and I kept trying to explain, you know I just don't like living in a place that you have to get by footpaths and I am on my own and don't know any one in this area and he carried on and told me to go and see the housing in Waterloo Place (housing department) for an interview.
CST3

Lizzie did not accept the tenancy and is waiting for another offer.

That seven respondents have been offered and refused a council tenancy because of the location and poor conditions of the dwelling and remain homeless is an important finding. Homeless applicants are in urgent need of housing. Housing managers use this fact to help them manage the waiting list. Typically, homeless applicants are forced to queue separately from the general needs waiting list for difficult to let stock that people on the general waiting

list are unwilling to accept. This policy serves a number of purposes - the principal of deterrence through poor standards is maintained, other stock is freed up for applicants on the general waiting list and the local authority is seen to be fulfilling its statutory duty to house homeless applicants. As homeless applicants are often the only people queuing for difficult to let stock, acceptance of this poor quality housing means they are likely to be housed relatively quickly. However, these seven respondents have reported that the stock that they have been offered is so bad that they prefer to remain homeless and wait for a better offer rather than move in. This is an important point. The implicit assumption in the government's recent review of the homelessness legislation (DoE, 1994) and the resultant White Paper on housing is that the homeless legislation is an 'attractive' route into council housing and that homeless applicants are jumping the queue ahead of people on the general waiting list. Both these suggestions are wrong. If homeless applicants are being rehoused relatively quickly it is not because they are jumping ahead of other applicants but because they are willing to accept poor quality housing which, in these respondents experience, is far from attractive.

Phil is 36 years old and has been homeless two months. Phil reported that he does not want to be homeless and would prefer to have a house or flat of his own. He recently received an offer from the council housing service. However, he reported having reservations about accepting the offer because he is unsure whether moving into an unfurnished council flat is really a step up and away from homelessness:

PHIL - A problem if you get a place is trying to get furniture and stuff.

DR - Can you get help with that?

PHIL: - No. That's to do with the income support, social security office and I have just been to see them.

DR - Have you had any success?

PHIL - I find out in a few days.

DR - Have you applied for a loan?

PHIL - A budgeting loan. I put down for everything 'cause I haven't got nothing. That was the problem with the homeless. You get a place, which is great, get out of here. You move in but you have got nothing. If they refuse me a budgeting loan they may only give me a crisis loan and then I've only got a couple of hundred quid which will be a cooker, bed and basically something to sit on, then you think you have got no carpet on your floor, you're walking into a dump, you have just got a cooker and a bed, so you are letting yourself go again so you might as well go back to homelessness. That's a problem for a homeless person. I mean I don't want a palace. I don't want big thick carpets or that. I just want something nice that I can move into and call a home, and then your standard of living will go up, but that is the problem with single homeless.

PHIL - So, you don't think that you are necessarily making a step up if you move in somewhere without furniture, bed, cooker..?

DR - You are going from bad to worse really because at least you are getting fed in here and that's one thing, you always get yourself fed in here.
PSP 5

Ten (10) respondents have been accepted onto a council house waiting list but not offered housing. These 10 respondents are aged between 18 and 60 years old, have been homeless between one month and five years and are living on the street, in short and long stay hostels, with friends and relatives and in supported accommodation. They are suffering from health problems that include manic depression, sleeping problems, alcohol dependency, eating problems, lethargy, flashbacks, problems with alcohol and drug use, walking problems, genito-urinary problems, aching joints and muscles, severe headaches/migraines, blackouts and respiratory problems. Four are in receipt of invalidity benefit. Two of the 10 expressed a preference for where they would like to live in their application and were told by housing department staff that if they are fussy they will have to wait two to three years. Three of the 10 reported that they have been told they do not have enough points and will have to wait a number of years before they receive an offer and five have no idea where they are on the waiting list.

6.3.4 Summary.

Medical priority is the outcome of a complex bargaining procedure between applicants, medical advisors and housing managers (Smith, 1989). Applicants have to convey need, medical advisors have to use discretion to assign priority and housing officers have to use discretion to balance medical need against increasing pressure on a stock that is declining in size and quality. Need is part of this bargaining procedure, but when the size and quality of council housing stock is declining and competition for access increasing, allocations may, in practice, be biased in favour of applicants most skilled at mobilising the medical priority system (Smith, 1989). Few, if any, of the 20 respondents accepted onto a council house waiting list were skilled at mobilising the medical priority system and only two are aware of been awarded priority on the grounds of their poor health.

Only four respondents reported that they have been deemed 'vulnerable' and in 'priority need' for reasons unrelated to health. Three were adjudged 'vulnerable' because of their age and one because violence forced her to leave her last home. All four have all been offered

accommodation. Another six respondents have also received an offer of housing from the council but none are aware on what grounds they have been awarded priority. However, all respondents remain homeless. Ten have not received an offer, eight have either accepted an offer and moved in and out again shortly afterwards or refused the offers they have received because of the poor condition of the dwelling or bad reputation of the estate, and two are waiting to move into housing they have recently been offered.

6.4 Conclusion.

Forty (40) respondents, all of whom are homeless, 38 of whom have health problems and the vast majority of who want a flat or house of their own have not been able to escape homelessness and re-enter the housing system because they cannot afford private rented housing and because social housing has not been selective in their favour.

A number of barriers have restricted access respondents' access to social housing. First, providers of social housing assume that people will find out about a service if they are in need. This assumption is wrong. Many respondents are unaware of housing associations, the accommodation they provide and how to apply. Many respondents are also unaware of the council housing service, the accommodation it provides and how to apply. Second, all housing associations and many local authorities devise eligibility criteria which stop some applicants from taking the first step in the allocation process. As a result, some respondents have been denied access to social housing for reasons unrelated to need. Third, applicants are only guaranteed an offer of housing if they are judged to be in need. However, the housing provider has to be aware of an applicants needs to be able to judge them worthy of priority. Many respondents did not know to mention their health and mobility needs when applying for social housing and few were awarded medical priority, even though all are homeless and the vast majority are suffering from mental and physical health problems. Fourth, homeless applicants are usually forced to queue for difficult to let council housing - poor dwellings in undesirable areas. The accommodation most respondents have been offered has been so bad that they have refused the tenancy even though they are in severe housing need and desperate for place of their own.

Social housing is a dwindling resource. Over the last 15 years the council housing stock has been savaged and the increase in housing association provision has failed to match this decline. During the same period demand has risen, even official statistics recognising a dramatic rise in the number of homeless people. To deal with rising demand and falling supply, housing managers have to adopt formal and informal rationing techniques. Given the welfare tradition in British public policy and the fact that local authorities are required by law to recognise certain priorities, it is assumed that the emphasis in the allocation of social housing is on fairness and demand is rationed on some basis of need. However, the experiences of the 40 homeless people interviewed in this study indicate that need does not always guarantee success in the allocation process. Ability to 'play the system' is also a significant factor, but contrary to the popular perception of people in need as skilled players of the welfare system, the vast majority of respondents in this study are unaware of how to maximise their chance of success, have failed to access social housing and remain homeless.

SUMMARY AND CONCLUSIONS.

In Britain there are no formal links between housing policy, health promotion and the provision of health care. However, this study has found clear links between housing provision and the health of homeless people. People with health problems are becoming and remaining homeless despite the welfare arm of the housing system, and homeless people are exposed to living conditions and poor servicing environments that are hazardous to health.

The 40 homeless men and women interviewed in this study are suffering from a range of mental and physical health problems and disabilities that impact on their everyday life and on their ability to play an active role in society - restricting employment opportunities, relationships with family and friends and everyday freedom. In an attempt to move the investigation process on from describing the health profile of homeless people to understanding its determinants, recall methods were used to collect health and homeless accommodation histories from 30 respondents. Twenty-five (25) of these 30 respondents reported that they had health problems before they became homeless and 28 of the 30 reported that they have experienced a change - usually a deterioration - in health since becoming homeless.

These findings point to two cause and effect relations that could explain the health profile of homeless people. First, the common experience of homelessness among respondents was of hazardous physical and social environments and inadequate health care, and since becoming homeless the majority of respondents have experienced a deterioration in their health. New problems have emerged and existing problems have got worse. It is difficult to account for the biomedical processes through which environment effects health, but these findings add weight to the evidence that homelessness is hazardous to health. Second, some people with health

problems are unable to avoid or escape homelessness, suggesting that the health profile of homeless people reflects, in part, the limited availability of secure accommodation for people with health problems.

This conclusion will highlight the significance of these findings and suggest how policy-makers might best tackle the health and homelessness problem. Underlying themes will be the role that housing policy can play as a health intervention and the need for housing to be integrated with social policy in order to provide a comprehensive package of housing, care and support. Theoretical conclusions will also be drawn regarding the welfare ideal that underlies current housing policy and the representation of homeless people in British society. Finally, suggestions will be made for further research.

7.1 Explaining the Health Profile of Homeless People.

In recent years concern has grown regarding the health of homeless people. Numerous studies have reported that the health profile of homeless people is considerably worse than that of the general population (see Chapter Three). They have shown too that homeless people's patterns of health service use are different - and inferior - to those of the more securely housed population. Researchers and policy-makers have responded to these findings by focusing on the provision of health care for homeless people. The implicit assumption has been that the problems homeless people encounter accessing and utilising health care have a significant impact on their health, although more general studies of the link between health and health care have been ambivalent in their findings. The experiences of the 40 homeless people interviewed in this study confirm that homeless people experience problems accessing and utilising health care but suggest that homelessness is hazardous to health in other more direct ways, and that health selective entry to and exit from the housing system are also significant determinants of the poor health profile of homeless people.

7.1.1 Homelessness is hazardous to health.

The evidence of Chapter Four is that few respondents have experienced difficulties registering with a GP and their use of hospital A and E departments has been limited to genuine accidents and emergencies. The majority of respondents are, however, receiving inadequate and

unsatisfactory care or have not sought medical help with some or all of their health problems because of a distrust of the health service and the belief that adequate care is not available. These findings confirm Shanks and Smith's (1992) assertion that the welfare ideal underlying the NHS is being compromised by the delivery of health care to homeless people. Respondents also reported problems accessing the care in the community they require, suggesting that the beneficial impact of the policy is limited by the workings of the housing system which is not providing for people in need of community care (Clapham, 1991). However, there is no obvious link between respondents' health histories and their utilisation of available health care. Inadequate health care rarely causes illness, and health interventions may not eradicate disease. What respondents' health histories do confirm is that a lack of health care support can exacerbate existing health problems. It is, therefore, crucially important that homeless people have adequate access to the full range of health care and practical and emotional support. This, however, is only part of the solution.

Inadequate and unsatisfactory health care can exacerbate existing problems but is not a direct cause of poor health. So, what risk factors could account for the impact of homelessness on health? In Chapter Four it was suggested that the environments people are exposed to when homeless offer a plausible explanation. The prevailing medical and political dictum is that the major causes of morbidity and mortality in contemporary British society are the product of lifestyle choices. However, there has been a recent revival of interest in the links between living conditions and poor health in response to the persistent and serious effects that post-war system built housing has had on the health of its residents and evidence that widening inequalities in health are closely associated with material deprivation. In Chapter Four the growing body of evidence that living conditions can initiate and exacerbate episodes of poor health was related to the situations and circumstances respondents have lived in since becoming homeless.

Although respondents' experiences were not identical, the vast majority reported that they have lived in environments where facilities were inadequate, unsafe or absent altogether, living space was cramped and overcrowded, individual freedom was limited, privacy was lacking and insecurity was ever present. In the light of evidence linking living conditions and health, it seems obvious that some of the health problems respondents have experienced since becoming homeless will stem from living in these conditions. For example, all respondents have lived in

cramped and overcrowded accommodation at some time since becoming homeless. Evidence suggests that degree of crowding in accommodation can have a significant impact on physical and mental health. Overcrowding increases the risk of transmission of disease and the death rates for particular infectious diseases are highly correlated with levels of crowding. Overcrowding also results in limited control over personal space and enforced social interaction which can have significant consequences for psychological health. Many respondents also reported feeling insecure. This is not surprising given that six have been victims of assault and the majority reported that they feel unsafe, have limited freedom over their everyday life and little privacy. Insecurity fosters stress and stress can precipitate psychiatric disorder. Seven respondents have slept rough and there is a catalogue of evidence linking disease, in particular cardiovascular and respiratory problems, to exposure to the cold and damp. Thirty (30) respondents have had problems accessing food preparation facilities since becoming homeless and reported problems maintaining a balanced and healthy diet and it has long been known that nutrition is important to health and well-being.

In summary, it is plausible to conclude that the social, physical and servicing environments homeless people are exposed to can initiate and exacerbate episodes of poor health.

7.1.2 Becoming and remaining homeless.

The possibility that the health profile of homeless people is, in part, a product of health selectivity out of and into the housing system was explored in Chapters Five and Six. Little attention has been paid by research to the issue of health selectivity in the housing system because it is assumed that if health selectivity exists it will favour people with health problems. This assumption reflects the welfare tradition so long a part of British housing policy and the fact that people with health problems have high priority among people eligible for council housing. However, recent evidence suggests that despite rules and regulations designed to ensure that applicants with health problems are given priority in housing association and council housing waiting lists, practice and procedure are failing to ensure that need guarantees success in the allocation process.

In Chapter Five it was reported that respondents left their last home out of necessity rather than choice, for example, because of relationship breakdown, disagreement with parents,

violence from a person they were living with, harassment and eviction. Most respondents left home in a rush and were unable to make plans about where to stay in advance. Their first concern was securing a roof over their head for the night, and because accessing permanent accommodation is a lengthy procedure they concentrated on accessing temporary accommodation. Although none wanted to become homeless and the majority were suffering from health problems, they were, therefore, forced out of the housing system and into homelessness. The four respondents who did attempt to access alternative permanent accommodation on leaving home all had warning that they might have to leave home and applied to the council housing service. However, none was offered housing before they left home. Therefore, 30 people, 28 of who were suffering from health problems, were ejected from the housing system and became homeless.

In Chapter Six it was reported that 40 homeless people, 36 of who have health problems and want a home of their own, have not been able to re-enter the housing system because they cannot afford private rented housing and have failed to negotiate the barriers that restrict access to social housing. Previous studies of health selectivity into housing association and council housing have focused on the procedures for dealing with medical priority needs. This study focused on 'consumer' issues and uncovered a number of additional barriers that prevent homeless people with health problems from accessing social housing and re-entering the housing system. First, it is assumed that if people need the help of a service they will apply. However, many respondents are unaware or unclear about the service provided by housing associations and the council housing service and have failed to apply. Second, some respondents have been denied access to housing association and council housing waiting lists for reasons unrelated to need, for example, because of rent arrears. Third, contrary to the belief that people in need are skilful players of the welfare system, most respondents are unaware on what grounds housing associations award priority and the majority are also unaware or unclear about the principal of medical priority and the statutory duty local authorities have to certain homeless people. Consequently, many respondents saw no reason to provide information about their health and when applying for social housing. Finally, most respondents who have been offered council housing reported that the dwelling they were offered was in such bad repair that they did not feel moving in would be a step up out of homelessness.

In summary, contrary to the assumption that if health selectivity exists in the housing system it works in favour of people with health problems, people with health problems are becoming and remaining homeless. The homeless people with health problems interviewed in this study have fallen between the priority need obligations of local authorities, the community care obligations of social service agencies and the value for money targets that housing associations are now expected to meet. Therefore, the health profile of homeless people is, in part, a product of people with health problems exiting and failing to re-enter the housing system.

7.2 Practical considerations - Policy Implications.

This study has identified two key factors that could explain the health profile of homeless people. This section will discuss how policy-makers might respond to these findings and realise the potential of housing policy to act as a positive health intervention, and will also consider how the politics of policy-making might compromise any attempt to tackle the poor health profile of homeless people.

7.2.1 Limiting the impact of homeless on health.

Homelessness is hazardous to health because being homeless restricts opportunity to access and utilise quality health and community care, and because the living conditions and lifestyles to which many homeless people are exposed are health threatening.

Improving access to and utilisation of health care.

Currently, the welfare ideal which initially underlay the NHS is being compromised because homeless people do not have an effective right to the full range of health care. Given the experiences of the homeless people interviewed in this study, I would argue that the only way to secure this right is to integrate the needs of homeless people into mainstream care.

Attempts to improve access to health care for homeless people have often concentrated on providing separate services that operate outside mainstream care and special services that offer a route into mainstream care. By offering an alternative to mainstream care, these

services have secured important improvements in the provision of care for homeless people. People have received care when otherwise they would have received none and unmet need has been identified so aiding the planning of future care delivery. It has also been suggested that separate and special services could facilitate the integration of homeless people's needs into mainstream care. Baylis (1993) argues that by providing a range of special services advocating on behalf of different groups and acting as a route into mainstream care, a flexible service could be created and the needs of homeless people integrated into the NHS. However, for individuals to reap the benefits of this plan they must be recognised as members of a defined group whose needs are targeted by a special scheme. Furthermore, evidence suggests that special services do not offer quality care comparable to that available at a normal GP's surgery and are often unsuccessful at integrating their users into mainstream care. Separate and special services are a response to the failure of the NHS to provide for homeless people and such are necessary and welcome. However, they are not a step toward an integrated health service.

Most practitioners consider the obstacles to integrating the needs of homeless people into the health service as insurmountable (Baylis, 1993). Integration demands ideological and practical restructuring of the NHS, restructuring that is likely to be unacceptable to dominant political, professional and financial interests. However, progress toward a more flexible health service that integrates the needs of homeless people into mainstream services might be possible by attending to the role of the GP. The GP lies at the heart of good and effective primary care service and is the source of referral to other professionals and agencies (Acheson, 1981). Although every person has the right in law to register with a GP, no GP is obliged to accept responsibility for a person wanting to register, unless assigned to their list by a Family Health Service Authority (Fisher and Collins, 1993). Consequently, patients are exposed to the risk of exclusion from care on the say so of a GP. A GP may choose to exclude a patient for any reason - diagnostic labelling, age or plain prejudice. Few respondents in this study have been totally excluded from a GP's services, largely due to the understanding of certain local GPs and the presence of a clinic for homeless people where access to a GP is guaranteed. However, the majority of respondents have been excluded to the extent that they are registered on a temporary basis. Consequently, their patient records have not been transferred from their last GP, disadvantaging the GP and the patient and making continuity of care impossible. As a result, many respondents reported that they have not received adequate or satisfactory care.

The logical solution to the exclusion of homeless people from quality health care is to force GPs to accept homeless people onto their patient lists by making the NHS GP service either salaried or patch based (Fisher and Collins, 1993). However, changing the current arrangement is likely to prove unacceptable to professional and political interests. A more pragmatic and achievable solution is to concentrate on the GP-homeless patient relationship. GPs are the gatekeepers of the NHS. By informing and educating GPs and debunking the prejudices that cause some GPs either to refuse homeless patients or to register them on a temporary basis, the main obstacle limiting access for homeless people to mainstream care would be removed. Challenging the stereotyping of homeless people as demanding, problematic and transient patients and making GPs aware of the lifestyles, circumstances and experiences of homeless people will help GPs to be more sensitive to the needs of homeless patients. At the same time, homeless people must be aware of their rights in a 'universal' health service. People should be informed what health care is available in their local area and have reason to be confident that there is a GP willing to see them who will be sensitive and sympathetic to their circumstances and provide quality care.

Separate and special services for homeless people provide a vital service but, paradoxically, reinforce the exclusion of homeless people from mainstream care. It has been suggested herein that a pragmatic way of tackling exclusion is to fight the prejudice that supports it, targeting attitudes via education. However, it would be naive to assume that 'education' is anything but a small part of the challenge. First, health service planners must recognise the unmet needs of homeless patients. Unfortunately, in a climate of care rationing and GP fund holding it is questionable whether the professional and political will exists to recognise an additional 'drain on resources'.

As well as the exclusion of homeless people from mainstream health care, this study has revealed that homeless people who need care and support are being excluded from the care in the community. The stated aim of care in the community is to foster independence so that people can stay in their own home. However, there is no reference in the legislation to the provision of care for people who do not have their own home and no agency has a statutory duty to provide housing for people who are homeless and in need of care and support. The experiences of respondents in this study confirm that homeless people with health problems are effectively excluded from the provisions of care in the community. Homelessness is not in

itself a community need, but community care client groups may be at increased risk of homelessness and may be disproportionately represented in the homeless population (SCSH, 1994). In response, community care plans should at least recognise homelessness issues within community care clients groups and foster consultation between social services and relevant housing and homelessness service providers. As Clapham (1991) points out, the situation can only be rectified if the objectives of community care are seen not as of marginal concern to housing policies but as objectives that underpin the whole of housing policy. However, there is a shortage of housing available for community care and there seems little hope of remedying the problem without an injection of resources (Spicker, 1993).

Improving living environments.

Given the wealth of evidence linking living conditions, material deprivation and poor health, and considering the conditions and lifestyles respondents have been exposed to since becoming homeless, it seems reasonable to suggest that enforcing minimum standards of occupation in temporary accommodation would improve quality of life and limit the impact of homelessness on health. To this end, housing policy should be employed as a health intervention. A mandatory licensing scheme should be introduced, supported by an improvement grant scheme, to remove the determinants of physical disease - cramped, overcrowded and unsanitary accommodation that lacks adequate facilities - and the social and environmental correlates of mental ill health - lack of personal space and privacy, limited personal freedom, harassment and violence - from temporary accommodation. All homeless people must be able to exercise a right to decent temporary accommodation that provides residents with some degree of security. For example, rather than being thrown out onto the street, people with alcohol and drug use problems should receive advice, support and care when wanted and needed. It is also vital that economic poverty, a key cause of distress, worry and insecurity and a reason why homeless people are often forced to adopt health threatening lifestyles, is eradicated. Benefits must cover the cost of board and lodging, regardless of age, and continue to help people with these costs if they secure employment.

Unfortunately, such a response to the poor health profile of homeless people is unlikely to be forthcoming. The government had an opportunity to show its commitment to decent living conditions for homeless people in the White Paper on housing, published in June 1995

following lengthy consultation about the future of the homeless legislation. In the White Paper the government proposes to extend the use of temporary private rented accommodation to house homeless people by removing the statutory right of homeless applicants in 'priority need' to council housing and forcing them to stay in private rented accommodation while waiting for housing on the general waiting list. Currently, many local authorities do not monitor standards in temporary accommodation, Lloyd et al. (1994) reporting that in their study of the management of homelessness in 274 English authorities only 75% use bed and breakfast accommodation in which standards are monitored and only 20% monitor standards in assured shorthold lets used as temporary accommodation. However, the White Paper contains no proposal aimed at improving living conditions in temporary accommodation. There is no plan to introduce a mandatory licensing scheme for temporary accommodation supported by an improvement grant scheme, merely the proposed introduction of incentives to encourage a discretionary licensing scheme on a local basis.

The government has also suggested capping Housing Benefit payments to individual claimants in response to the country's fiscal crisis and as part of the long term search for reductions in welfare state expenditure that is rooted in the neo-liberal belief that social spending restricts economic growth (Kemp, 1994). It is not clear what the impact of capping Housing Benefit payments will be, but it is possible that if a tenant's rent exceeds the fixed level Housing Benefit payment they will be faced with the choice of either topping up rent payments out of their social security benefit or moving into alternative, cheaper accommodation. This scenario will only be avoided if property owners accept a cut in their profits or, as is more likely, maintain profit levels by reducing investment in the stock or increasing tenant numbers. Tenants will, therefore, either be faced with increasing poverty and insecurity or falling standards in their accommodation.

In summary, an effective way to limit the impact of homelessness on health might be to employ housing policy as a health intervention by improving the conditions in temporary accommodation. The social security system might also be employed as a health intervention by limiting the financial insecurity and uncertainty of being homeless and alleviating the health threatening lifestyles related to economic poverty. Ultimately, however, the most effective health intervention would be to limit the number of people who are homeless and the length of time people are exposed to the hazards homelessness.

7.2.2 People with health problems must be able to escape homelessness.

During the last 16 years, British housing policy has focused on the creation of a 'property owning democracy'. Owner occupation has been heavily subsidised through tax breaks to mortgage holders and the market model of provision now dominates the housing system. However, the housing market is in no way aligned to the welfare ideal (Smith, 1991). It is regressive rather than redistributive (the higher a household's mortgage capacity, the more it benefits from tax exemptions) and access is based on ability to pay. People unable to pay are reliant on the provision of rented accommodation.

The private rented sector now only accounts for nine percent of the housing stock and the majority of remaining supply is expensive and insecure. Therefore, the majority of households unable to secure a sufficiently large and stable income to repay a mortgage or deposit are reliant on housing association or council housing provision. However, during the last 16 years there has been a relative and absolute decline in the supply of social housing. The council housing new build program has been halted and existing stock has been sold off through discount sales to sitting tenants and estate privatisation, but this decline has not been matched by increased provision by housing associations, the politically favoured suppliers of social housing. With the social housing stock diminishing, the council housing service and housing associations face increasing difficulty providing adequate housing for the record numbers of homeless applicants and are forced to exercise discretion in order to limit demand and ration supply. The experiences of the homeless people interviewed in this study suggest that rationing has introduced barriers that restrict access to social housing for reasons other than individual need. Consequently, people with health problems are exiting from and failing to re-enter the housing system. In response, it is vital that supply of social housing is increased through a re-energised social sector - liberal estimates report a need for 100,000 units per year of social housing provision to meet projected need in England alone (Niner, 1989; Bramley, 1991; Whitehead and Klienman, 1992). Demand must also be limited by providing practical and financial support to prevent people with health problems falling out of the housing system.

Housing policy should provide support to people with health problems who are unable to work on an intermittent or permanent basis so that they do not have to leave home because of loss

of earnings. Working in tandem with housing policy, social policy should be employed to ensure that people are not forced to leave home and become homeless because they cannot manage practically in independent housing. This will involve recognising that decent housing is crucial for the development of appropriate care, and that care and support is crucial to ensure security of tenure. Underlying the incorporation of housing into social policy must be a re-energised public rented sector that is able to fulfil an obligation to provide accessible and affordable, good quality housing to people who fall out of the housing market, people who are homeless and want to re-enter the housing system and people who prefer to remain in the public sector rather than enter the housing market. Public renting must be the vehicle of this more effective and efficient social housing because the free market is incapable of providing all households with an acceptable standard of housing (Klienman, 1987). The more caring and effective practices of housing associations must be combined with the proven relative economic efficiency of local authority provision (MacLennan, 1989). The refusal of respondents in this study to accept an offer of council housing and to instead remain homeless questions, however, the ability of the public sector to provide housing of a satisfactory standard to meet the needs of homeless people with health problems. Forced to queue separately for difficult to let stock that people on the general waiting list are unwilling to accept, seven out of ten respondents offered council housing refused the tenancy because of the lack of basic amenities (such as a bed, cooker and fridge) and the location and physical condition of the dwelling. These experiences confirm the dominant image of council housing as decaying dwellings in poor repair, located on run-down, lawless estates. These problems do not, however, represent an inherent failing in council housing, but stem from its status as a residualised, neglected and chronically underfunded tenure (Malpass, 1988).

The large amount of system built dwellings constructed in the public sector from the 1950s to the 1970s are showing physical problems, such as dampness and mould growth (Conway, 1995), and their design has been blamed for a whole range of social problems (see Coleman, 1985). These problems are the product of unsatisfactory design solutions to government restrictions on housing construction costs and minimum quality standards (Malpass and Murie, 1990). The narrow focus on space standards and equipment levels ignored other vital design aspects such as technical and architectural innovation and the external environment, and cost cutting produced various combinations of poor basic design and inadequate on site procedures resulting in deficiencies such as materials failure, poor insulation, ineffective

heating systems and water penetration (Cole and Furbey, 1994). This apparent 'failure' of the design and physical quality of council housing was exploited by the Conservative government during the 1980s to justify ending the new build program and the drive toward privatisation. There is evidence, however, that given the necessary investment in management and maintenance, high rise blocks can be successful for many households (Anderson et al., 1985), and the remaining majority of council housing, mainly two storey houses, when maintained and upgraded can offer decent standards (Cole and Furbey, 1994). Given the reversal of years of neglect and underfunding through a program of renovation and new build, public housing could provide dwellings of satisfactory standard at prices people in need can afford. These are the reasons why public sector housing was set up under the Addison Act of 1919, and these are the reasons why public sector housing must be revived today.

Unfortunately, it is unlikely that policy-makers will rediscover the potential of housing to serve as a health intervention given the market orientated straight-jacket that is currently restraining housing policy. The restructuring of housing provision away from subsidised renting and towards subsidised home ownership has led the restructuring of the welfare state along neo-liberal lines (Shanks and Smith, 1992). For the government to acknowledge that the decline in subsidised rented housing has coincided with a rise in homelessness and demand outstrips supply to the extent that need is no guarantee of success in the allocation process would involve recognising that their flagship policy - the creation of a 'property owning democracy' - has had many victims.

7.3 Theoretical Conclusions.

This study has identified a number of ways in which housing policy might be used to advance the aims of health and social policy. In this section some conclusions are drawn about why housing policy is not being employed in the pursuit of social goals. The first theme is the shift in political ideology that underlies the declining popularity of social arguments for state intervention in the housing system. The second theme is the reflection of this ideology in the representation of homeless people.

7.3.1 Housing policy in the age of neo-liberalism.

The state has long recognised that housing is a determinant of opportunity and employed housing policy to achieve social goals. The key instrument used to achieve social objectives in housing has been council housing (Clapham, 1989). The main social gain of council housing has been the freeing of disadvantaged people from bad housing and homelessness through allocation policies that assign property to people in housing need. The employment of housing policy to achieve social goals reflects the social democratic welfare ideal that informed post-war public policy. The guiding principal of this ideal is equality as a right to ensure social integration and justice. However, in the last 15 years there has been a shift in the emphasis of housing policy away from an interventionist stance and the achievement of social goals, and toward the satisfying of political and economic considerations (Clapham et al., 1990). This shift reflects the rise in political popularity of the 'New Right' or neo-liberal model of welfare provision.

The New Right welfare ideal is centred on a much larger role for the market and the reduction of the state's role to that of minimal safety net provision. The guiding principals are that state welfare is damaging to individuals by creating 'dependence', and that state spending crowds out private agencies and investment that are more efficient. Housing policy has been used to lead the restructuring of the welfare state along these neo-liberal lines, the emphasis switching from the achievement of social goals through the provision of council housing to the creation of a 'property owning democracy'. Subsidised home ownership has been actively encouraged and the council housing sector has been reconstituted as a safety net tenure intended to counter the harmful effects of the housing market on financially weaker households. This shift in housing provision has, almost wholly, been justified by the resultant savings in spending on housing. However, when expenditure on mortgage tax relief and housing benefit are taken into account it becomes clear that there has been a major redistribution of spending on housing rather than a saving. This redistribution has been from the public sector to home ownership. The subsidisation of the production of public housing has been ended in favour of the subsidisation of private individual consumption, for example, mortgage interest tax relief at source (Malpass and Murie, 1990). Housing subsidies in Britain have, therefore, become increasingly regressive rather than progressive.

The findings of this study question the wisdom of this new logic of welfare provision and the redistribution of spending on housing. Housing inequalities are widening, as is shown by the recent dramatic rise in homelessness, the safety net of social housing cannot cope with demand and need no longer guarantees access to housing. Consequently, people unable to attain or maintain a place in the housing market, for example, because of intermittent or persistent health problems, are becoming and remaining homeless. The experiences of respondents also illustrate that housing inequalities produce and exacerbate other forms of inequality, for example, in health. However, the New Right ideal views inequality of outcome as not only tolerable, but vital to economic growth.

Post-war housing policy reflects the shifting popularity of the social democratic and the neo-liberal welfare ideals. The evidence of this study is that the recent shift toward the neo-liberal ideal of welfare provision has had many victims and has undermined the social achievements of post-war housing policy. In response, it has been argued that housing policy could and should once again be employed as a tool for achieving social goals, and specifically, as a positive health intervention. People with health problems are becoming homeless and being exposed to harsh physical and poor servicing environments because of a lack of adequate and affordable housing. Housing policy has the potential to serve as a positive health intervention by limiting the number of people who become homeless, ensuring that people who are homeless are not exposed to the hazardous living conditions and poor servicing environments for any length of time and limiting the impact of homelessness on health by maintaining decent standards in temporary accommodation. Whether or not housing policy will be employed as a tool for tackling inequality will depend on what model of welfare provision prevails.

7.3.2 The representation of homeless people.

This study is witness to the fact that the shift in the emphasis of housing policy away from the achievement of social goals and toward satisfying economic and political considerations has had its victims. Research into the characteristics and causes of homelessness has recognised that increasing levels of homelessness are the consequence of economic and labour market changes and inadequate provision of housing (Murie, 1988). However, there is little political will to tackle the crisis of homelessness in Britain today. The welfare state continues to be

eroded in favour of market provision, subsidised home ownership is pursued at the expense of subsidised social housing, and the homeless legislation is under threat.

The reason for the lack of political will to tackle homelessness is that alleviating the problem necessitates direct state intervention in the housing system to achieve a social goal, and the market model of housing provision, which currently attracts political legitimacy and much public support, is opposed to such intervention. However, even the government's own statistics point to a dramatic recent increase in the number of homeless households and all available evidence suggests that demand for social housing outstrips supply, so how do policy-makers justify their inaction?

The lack of political commitment to tackle homelessness is justified in large part through the representation of homeless people that dominates in British society. Typically, homeless people are portrayed as an homogenous group who are deviant, dysfunctional and individually responsible for their predicament. This is particularly true of single homeless people who are represented as welfare scroungers who are homeless out of choice and follow a life of alcoholism, drug abuse and criminality. Held personally responsible for becoming and remaining homeless, homeless people are regarded as undeserving of help. Consequently, policy-makers are freed from any responsibility for the crisis of homelessness and able to justify punitive measures against homeless people.

The negative representation of homeless people is evident in the measures proposed in the recent White Paper on housing (June, 1995). Currently, the homeless legislation excludes most single homeless people from any statutory right to council housing, and applicants accepted as homeless are treated as undeserving or less desirable than other applicants (Murie, 1988). In response to the recent dramatic rise in homelessness, rather than extending the statutory duty of the council housing service to house homeless people, the government has proposed to end the council housing service's responsibility to all homeless people. Pressure groups and agencies working with homeless people have responded to the governments proposals by arguing that homelessness is an extreme form of housing stress experienced by ordinary people and that, although the legislation is flawed and compromised by a lack of resources, withdrawing it would condemn increasing numbers of people to homelessness. However, the proposed changes have been justified by implying that people are becoming

homeless in order to take advantage of the 'attractive route' into council housing available to homeless applicants who jump the queue for housing ahead of people on the waiting list (DoE, 1994).

In Chapters Five and Six, it was shown that the reasoning behind the proposed reform of the homeless legislation is based on incorrect assumptions. First, the vast majority of respondents did not become homeless out of choice and do not want to remain homeless. Second, the homeless legislation is not an 'attractive route' into council housing. Many respondents are unclear about how to apply for council housing and unaware of the statutory duty that the service has to house homeless applicants in medical need, and have been unable to mobilise the allocation process in their favour. Respondents who have successfully negotiated access through the homeless route have been offered accommodation in poor condition in undesirable areas. Third, homeless applicants do not jump the queue ahead of people on the general waiting list. The reason why homeless applicants who are successful in the allocation process are rehoused relatively quickly is because they are offered difficult to let stock that no one on the waiting list is willing to accept. Although questionable, the government's reasoning is politically convenient because it shifts attention away from the inadequate provision of social housing and onto the allocation of a dwindling stock. Therefore, blame is transferred from the restructuring of the welfare system along new ideological lines and onto the supposed deviance of homeless people and the failings of local authorities as landlords. Consequently, the government is able to justify withdrawing support for the homeless legislation and running down the social rented sector.

Policy-makers are responding to the plight of homeless people with increasingly punitive measures on the grounds that homeless people are undeserving and deviant. Within this constrained context there is little chance of policy responding to the poor health profile of homeless people. Therefore, it is vital that researchers and pressure groups whose aim is to alleviate homelessness engage policy-makers and the public in a debate about the realities of homelessness in Britain and challenge the negative representation of homeless people.

7.4 Suggestions for Future Research.

Previous studies of health and homelessness have revealed, through cross-sectional analysis, a

high incidence of a range of mental and physical health problems among homeless people. Attempts to manage this poor health profile have focused on the provision of health care. In this study, through the longitudinal analysis of health and homeless accommodation histories, it has been revealed that the health profile of homeless people might also be a product of the hazardous environments in which homeless people often live and a product of people with health problems becoming and remaining homeless. This section will conclude by proposing how new research might build on these findings, and how researchers might take forward some of the developments made in this work.

7.4.1 Homelessness is hazardous to health.

The evidence of Chapter Four suggests that homelessness is hazardous to health and can initiate and exacerbate episodes of poor health. In response, research might attend to three key issues. First, there is a need for a comprehensive assessment of special and separate health care services for homeless people. Second, there is a need to develop awareness of the provision of community care for homeless people. Third, research should investigate the environmental determinants of physiological and psychological ill health and inform future revisions of standards in temporary accommodation.

Separate and special health services have secured important improvements in the provision of health care for homeless people. However, the experiences of homeless people interviewed in this study concur with the suggestion that the ad hoc provision of health care for homeless people does not provide quality care comparable to that available in an ordinary GP's surgery, and does not integrate homeless patients into mainstream care (see Chapter Four). What is required of researchers is an extension of previous case studies of health care initiatives for homeless people to a national level. This might involve assessing the demand for and availability of health care initiatives for homeless people, leading perhaps to an assessment of good practice and a discussion of the role that special services can hope to play, either as a segregative or integrative service.

The problems experienced by respondents in need of care and support magnify the deep-seated inflexibility of the health and social services in providing care for people without permanent accommodation. More information is, therefore, required about the incorporation of housing

into community care provision. Researchers might monitor if and how local authorities attend to the needs of homeless people in their community care plans, and perhaps recommend best practice procedures for the development of a link between housing and community care provision.

This study has suggested that the conditions in which many homeless people live are an important determinant of poor health. In response, research might first establish a more comprehensive understanding of the biomedical processes that link homelessness and poor health. This will involve the collection of longitudinal data so that the impact on health of time and place specifics can be appreciated and the direction of cause and effect relations understood. Consequently, research might be able to inform future revisions of standards in temporary accommodation and monitor the effects of environmental improvements on the health of residents.

7.4.2. Health selective exit from and entry to the housing system.

Chapters Five and Six reported that people with health problems are becoming and remaining homeless despite the fact that people in housing need and with health problems have high priority among people eligible for council housing. There is, therefore, an urgent need to understand why the health, housing and social services are failing to ensure that people with intermittent or permanent poor health do not become homeless. Recent studies have gone some way toward developing a comprehensive understanding of the procedures for dealing with medical priority needs in housing associations and the council housing service. This study has illustrated that informal rules and 'consumer' issues are also important determinants of the outcome of the allocation process and the failure of people with health problems to secure permanent accommodation.

The majority of respondents in this study have either not applied for social housing or have withheld information about their health when applying because they were unaware or unclear about the principal of medical priority. This finding suggests that the real level of need for rehousing on health grounds is currently being underestimated. In response, it is important to establish the real level and nature of need for rehousing on the grounds of health, perhaps through a national quantitative study. In tandem with this quantitative agenda, it is important

that research determines the potential for rehousing to act as a health intervention. This will involve monitoring, through longitudinal study, the qualitative impact of rehousing on health and evaluating to what extent the potential of rehousing to serve as a positive health intervention is being compromised by the conditions in dwellings made available to homeless applicants.

Vital to the success of this research agenda will be the co-operation of medical and social science research. Medical research will bring an understanding of the relative efficacy of various factors as risks associated with ill health. Social science research will bring an ability to look beyond the presence of recognisable physiological or psychological disorder and recognise that the impact of health on everyday life and role in society are also significant dimensions of health. This was the role of the health related quality of life questionnaire devised for this study, and there are a number of benefits of the approach adopted that are worth noting. First and foremost, health related quality of life schedules are criticised as being 'too subjective'. However, the ability to be a reactive participant in the interview process was a strength of my questionnaire. Semi-structured questioning about health and everyday life - problems walking, mobility, being worried or tense, feeling down, being in pain - uncovered limitations in functioning. Questioning about health and role in society - treatment by other people, employers, benefit agencies, housing providers and impact on related opportunities - uncovered limitations in the role played in society. Furthermore, the fact that I, the interviewer, was not a health professional and the interview was not clinically based seemed to free respondents to reveal and discuss problems they had chosen not to reveal to a health professional. As a result, a range of health problems that might go unrecognised in a clinical study were revealed. Another beneficial aspect of the questionnaire design was that, in conjunction with recall techniques, it allowed the collection of retrospective health data that was otherwise inaccessible, medical records being difficult to access and likely to be incomplete given the difficulties homeless people experience accessing and utilising health care. The health related quality of life questionnaire devised for this study might therefore be a useful survey tool for implementation by a non-health professional in order to: describe the functional, social and organic health of a specified group, for example, homeless people or the elderly; evaluate the impact of a medical or social intervention on an individual's health status by comparing the impact of health on everyday life and role in society before and after intervention; use in addition to clinical interviews to collect data regarding the social and

functional dimensions of health and; collect retrospective data when no other source is available or accessible.

Social science research will also bring to this research agenda an ability to look beyond the medical dictum that the major causes of ill health are the result of lifestyle choices.

Inequalities in health are closely associated with material deprivation and it has been suggested that measures to reduce differences in the material standard of living could have a significant role in reducing inequalities in health. It is, therefore, important that research that aims to investigate the health profile of homeless people and realise the potential of housing to serve as a health and social policy intervention appreciates the socio-economic determinants of ill health.

7.4.3 The experiences of homeless people with health problems from minority ethnic groups.

It was acknowledged in Chapter 2 that this study has failed to access the accounts of homeless people from minority ethnic groups. It is important, given that racism produces manifest social inequalities in housing and health in contemporary Britain, that research tackles this failing.

Research studies on 'race' and housing have documented overt racial prejudice and discrimination: by key individuals in the housing consumption process (subjective racism), including private landlords, estate agents and housing department officers; by policy and administrative processes in local housing agencies (institutionalised racism), including local authority housing departments, building societies and estate agents and; by aspects of national processes that impact on black people's housing experiences (structural racism), including housing policy and labour markets (Ginsberg, 1993). It is not, therefore, surprising that the limited evidence available regarding homelessness among minority ethnic groups documents a higher proportion of black people than white people being officially accepted as homeless, and black applicants being treated less favourably (Bonnerjea and Lawton, 1987). In particular, evidence suggests that the burden of homelessness is increasingly falling on black women and young black people (Bonnerjea and Lawton, 1987, O'Mahoney, 1988). Abundant evidence also documents racialised inequalities in health (Ahmad, 1993). These findings are not surprising; racialised inequalities in employment, income, education, housing and along other

major indices of quality of social existence highlight a situation rife for generating inequalities in health and health care (Donovan, 1986; Ahmad et al., 1989). It is therefore reasonable to suggest that the manifest effects of racism on housing opportunities, access to and utilisation of health care, and health status will impact on the experiences of homeless people with health problems from minority ethnic groups. There is therefore an urgent need to assess the distinctive experiences of racialised minorities. To this end, projects which target the specific experiences of people from minority ethnic groups will be important. However, as Smith (1992) points out, it is also crucial that analysts insert a form of 'race' awareness into mainstream research.

It is vital to the success of this research agenda that the politics of health research is acknowledged. First, it is important that black people are no longer excluded from defining their own realities as researchers and as subjects of research (Ahmad, 1993). Second, it is vital to look beyond culturalist approaches, that explain racialised differences in health and health care as resulting from cultural differences and deficits, and epidemiological approaches which claim to make value-free observations on evidence gleaned from scientific methodology and dismiss 'race' and class as political irrelevancies. As Ahmad (1993) points out, racialised inequalities in social relationships between black and white people are at the base of racial health inequalities.

7.5 Conclusion.

The Government has acknowledged that decent housing is a prerequisite of good health and made a promise to promote choice and quality in housing in The Health of the Nation White Paper. They have, however, failed to address the issues that this raises for the health of homeless people. Energy directed at tackling the health and homelessness problem has focused on the search for health policies to secure improved medical care for homeless people, and neglected the links between the health profile of homeless people and housing policy and provision. The medicalisation of the health and homelessness problem reflects political embarrassment over homelessness in a context where housing policy has pioneered the shift from state to market provision favoured by neo-liberalism (Clapham, et al., 1990). To divert attention away from the politically sensitive issue of housing availability, policy-makers have turned the spotlight onto health care provision, making the providers of primary care

scapegoats. The problem has been packaged as a failing of the NHS rather than the restructured housing system.

Unfortunately, research has failed to offer a serious challenge to the narrow scope and orientation of debate regarding the health of homeless people. Epidemiological studies, rooted in the medical dictum that the major causes of mortality and morbidity are the product of lifestyle choices, have failed to move debate on from describing to understanding the determinants of the health profile of homeless people, and housing studies have struggled to come to grips with, and accommodate, key questions regarding the interplay between health and housing opportunities. However, with increasing attention being paid to the interface between housing and social policy, evidence has begun to emerge indicating that homeless environments impact on health and health is a determinant of housing opportunity. Building on this evidence, this study has sought to contribute in a number of ways to understanding the determinants of the health profile of homeless people: exposing the environmental precursors of poor health; illuminating the links between homelessness and difficulties accessing and utilising health care; and exploring the mechanisms by which people with health problems become and remain homeless. In each of these cases the links between homelessness and health are sufficient to question the ministerial, policy making and practical separation of housing policy from action to tackle the poor health profile of homeless people.

In conclusion, this study's findings confirm that the health of homeless people is a housing issue. In response, it has been argued that housing policy is a health intervention appropriate to the needs of homeless people and should be considered an integral part of social policy.

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APPENDIX 1

<u>Name</u>	<u>Interview code</u>	<u>Age</u>	<u>Sex</u>	<u>Current health problems</u>	<u>Health problems when last at home</u>	<u>Currently registered with a GP?</u>	<u>In receipt of sickness/invalidity benefit?</u>	<u>Current accommodation</u>	<u>Last home</u>	<u>Accommodation since becoming homeless/last 5 years</u>	<u>Length of time homeless</u>	<u>Location of interview</u>
Callum	BDG 1	19	male	Asthma Stress	Asthma Drug abuse Depression	yes	no	Temporary supported accommodation for young people	Council Flat - Living alone	B and B 'hotels'	4 months	Support service for young people
Cameron	BDG 2	21	male	Drug abuse Flashbacks Lethargy Paranoia Sleeping probs	none	yes	no	Temporary supported accommodation for young people	Parental home	Sharing - friends Hostels Sharing - relatives Prison	5 years	Support service for young people
Gill	BDG 3	20	female	Alcohol - dependency Suicidal - depression	Alcohol - dependency	no	no	Sharing - friends	Parental home	Sharing - friends Supported accom. Hospital Hostel	4 years	Support service for young people
Cathy	ADC 1	28	female	Manic - depression	Manic - depression	yes	yes	Sharing - family	Housing Assoc. flat - Sharing with partner	Current Accom.	1 month	Advice centre for homeless people
Pete	ADC 10	42	male	Angina Depression Alcohol - dependency	N/A	yes	yes	Direct access hostel for homeless men	N/A	Prison Supported accom.	7 years	Advice centre for homeless people

<u>Name</u>	<u>Interview code</u>	<u>Age</u>	<u>Sex</u>	<u>Current health problems</u>	<u>Health problems when last at home</u>	<u>Currently registered with a GP?</u>	<u>In receipt of sickness/invalidity benefit?</u>	<u>Current accommodation</u>	<u>Last home</u>	<u>Accommodation since becoming homeless/last 5 years</u>	<u>Length of time homeless</u>	<u>Location of interview</u>
Annie	ADC 11	45	female	Manic - depression Bronchitis Urinary probs eating probs	Manic - depression	yes	yes	Direct access hostel for homeless men	Council flat - sharing with partner and children	B and B 'hotels' Sleeping rough Prison	6 years	Advice centre for homeless people
Gerry	ADC 12	57	male	Anxiety/stress Back pains Sleeping probs	N/A	no	yes	Direct access hostel for homeless men	N/A	Hostels Bedsit	+ 20 years	Advice centre for homeless people
Helen	ADC 2	25	female	Anxiety/stress Sleeping probs	Anxiety/Stress Lethargy	no	no	Women's refuge	Council flat - Living alone	Temporary council flat	2 years	Advice centre for homeless people
Andy	ADC 3	34	male	Stomach ulcer Anxiety	Stomach - ulcer	yes	no	Direct access hostel for homeless men	Mortgaged house - sharing with fiancée and child	Sharing - friends hostel	1.5 years	Advice centre for homeless people
Ian	ADC 4	18	male	Knee pains - walking probs Asthma Depression Colds/flu Behavioural problems	Knee pains Personality - disorder	yes	no	Sleeping rough	Council flat - Living alone	Hostel	2 months	Advice centre for homeless people

<u>Name</u>	<u>Interview code</u>	<u>Age</u>	<u>Sex</u>	<u>Current health problems</u>	<u>Health problems when last at home</u>	<u>Currently registered with a GP?</u>	<u>In receipt of sickness/invalidity benefit?</u>	<u>Current accommodation</u>	<u>Last home</u>	<u>Accommodation since becoming homeless/last 5 years</u>	<u>Length of time homeless</u>	<u>Location of interview</u>
Colin	ADC 5	45	male	Alcohol - dependency Liver probs Depression Aching joints	none	yes	no	Direct access hostel for homeless men	Council flat - sharing with partner and children	Sleeping rough Hostels	5 years	Advice centre for homeless people
Jimmy	ADC 6	19	male	Depression Eating probs - Weight Loss	Drug - dependency Paranoia Eating - problems	yes	yes	Temporary supported accommodation for young people	Council tenancy - Living alone	Sharing - friends Hostel	7 months	Advice centre for homeless people
Willie	ADC 7	20	male	Anxiety/stress Scabies Leg pains Personality - problems	N/A	no	no	Sleeping rough	N/A	Sharing - friends Hostels Sleeping rough Prison	5 years	Advice centre for homeless people
Dave	ADC 8	37	male	Partial sight alcohol - dependency Varicose veins Sleeping probs Bronchitis Blackouts	N/A	yes	yes	Direct access hostel for homeless men	N/A	Hostels Sleeping rough	14 years	Advice centre for homeless people

<u>Name</u>	<u>Interview code</u>	<u>Age</u>	<u>Sex</u>	<u>Current health problems</u>	<u>Health problems when last at home</u>	<u>Currently registered with a GP?</u>	<u>In receipt of sickness/invalidity benefit?</u>	<u>Current accommodation</u>	<u>Last home</u>	<u>Accommodation since becoming homeless/last 5 years</u>	<u>Length of time homeless</u>	<u>Location of interview</u>
Dan	ADC 9	29	male	Back pains Lethargy Flashbacks Depression Eating probs	Drug use Lethargy Anxiety/Stress	no	no	Temporary supported accommodation for young people	Council tenancy Living with partner	Sharing - relative Hostels	6 months	Advice centre for homeless people
Lesley	BDR 1	17	female	-	Asthma	yes	no	Supported temporary accommodation for young people	Parental home	Sharing - friends Hostels	1 year	Supported accom. for young people
Gary	BDR 2	20	male	Migraines Stress	Migraines	yes	no	Supported temporary accommodation for young people	Tied accommodation	Hostel	1 year	Supported accom. for young people
Rachel	BDR 3	17	female	Anxiety/stress	Depression Behavioural-problems	yes	no	Supported temporary accommodation for young people	Parental home	Sharing - friend School	1 year	Supported accom. for young people
Michael	C'DC 1	54	male	Manic - depression	Manic - depression	yes	yes	Direct access hostel for homeless men	Council tenancy Living alone	Current Accom.	2 months	Day centre for homeless people

<u>Name</u>	<u>Interview code</u>	<u>Age</u>	<u>Sex</u>	<u>Current health problems</u>	<u>Health problems when last at home</u>	<u>Currently registered with a GP?</u>	<u>In receipt of sickness/invalidity benefit?</u>	<u>Current accommodation</u>	<u>Last home</u>	<u>Accommodation since becoming homeless/last 5 years</u>	<u>Length of time homeless</u>	<u>Location of interview</u>
<i>James</i>	<i>CDC 2</i>	<i>55</i>	<i>male</i>	<i>Diabetes Stomach ulcer Respiratory - probs Alcohol - dependency Urinary probs</i>	<i>N/A</i>	<i>yes</i>	<i>no</i>	<i>Lodging house</i>	<i>N/A</i>	<i>Hostels B and B 'hotel'</i>	<i>+ 5 years</i>	<i>Day centre for homeless people</i>
<i>Mick</i>	<i>CDC 3</i>	<i>51</i>	<i>male</i>	<i>Leg pains - probs walking Flu/colds</i>	<i>N/A</i>	<i>no</i>	<i>no</i>	<i>Sleeping rough</i>	<i>N/A</i>	<i>Current accom.</i>	<i>+ 5 years</i>	<i>Day centre for homeless people</i>
<i>Tony</i>	<i>CDC 4</i>	<i>49</i>	<i>male</i>	<i>Blackouts Aching joints - probs walking Sleeping probs</i>	<i>N/A</i>	<i>yes</i>	<i>yes</i>	<i>Squatting</i>	<i>N/A</i>	<i>Sleeping rough Hostels</i>	<i>10 years</i>	<i>Day centre for homeless people</i>
<i>Harry</i>	<i>CDC 5</i>	<i>50</i>	<i>male</i>	<i>Schizophrenia</i>	<i>N/A</i>	<i>yes</i>	<i>yes</i>	<i>Direct access hostel for homeless men</i>	<i>N/A</i>	<i>Current accom.</i>	<i>14 years</i>	<i>Day centre for homeless people</i>
<i>Robbie</i>	<i>PSP 1</i>	<i>68</i>	<i>male</i>	<i>Arthritis - walking probs Urinary probs Sleeping probs Alcohol - dependency</i>	<i>N/A</i>	<i>yes</i>	<i>no</i>	<i>Direct access hostel for homeless men</i>	<i>N/A</i>	<i>Current accom.</i>	<i>+ 10 years</i>	<i>Hostel for homeless men</i>

<u>Name</u>	<u>Interview code</u>	<u>Age</u>	<u>Sex</u>	<u>Current health problems</u>	<u>Health problems when last at home</u>	<u>Currently registered with a GP?</u>	<u>In receipt of sickness/invalidity benefit?</u>	<u>Current accommodation</u>	<u>Last home</u>	<u>Accommodation since becoming homeless/last 5 years</u>	<u>Length of time homeless</u>	<u>Location of interview</u>
John	PSP 2	33	male	none	none	no	no	Direct access hostel for homeless men	Mortgaged - house Living with partner	Sharing - friend	5 years	Hostel for homeless men
Doug	PSP 3	20	male	Sleeping probs Lethargy Migraines Anxiety Learning - difficulties	Learning - difficulties Migraines	yes	yes	Direct access hostel for homeless men	Council tenancy Living alone	Hostels Lodging house Housing Assoc. - tenancy Temporary - council flat Bed and breakfast	1 year	Hostel for homeless men
Les	PSP 4	42	male	Blackouts Lethargy Respiratory - probs Depression Headaches	Blackouts Lethargy Anxiety Respiratory - problems	yes	no	Direct access hostel for homeless men	Council tenancy Living alone	Current accom.	2 months	Hostel for homeless men
Phil	PSP 5	36	male	Sleeping probs Eating probs Depression Anxiety/Stress	none	no	no	Direct access hostel for homeless men	Council tenancy Living with partner	Sharing - friend	2 months	Hostel for homeless men
Ray	PSP 6	32	male	Chest pains Personality - probs	Chest pains Personality - probs Blackouts Anxiety	yes	no	Direct access hostel for homeless men	Parental home	Prison Sleeping rough Sharing - relative	2 years	Hostel for homeless men

<u>Name</u>	<u>Interview code</u>	<u>Age</u>	<u>Sex</u>	<u>Current health problems</u>	<u>Health problems when last at home</u>	<u>Currently registered with a GP?</u>	<u>In receipt of sickness/invalidity benefit?</u>	<u>Current accommodation</u>	<u>Last home</u>	<u>Accommodation since becoming homeless/last 5 years</u>	<u>Length of time homeless</u>	<u>Location of interview</u>
Charlie	PSP 7	65	male	Angina Bronchitis Suicidal - depression	Angina Suicidal - depression	yes	yes	Direct access hostel for homeless men	Council tenancy Living alone	Hospital B and B 'hotels' Sharing - friends Hostels	9 months	Hostel for homeless men
Sandra	SFD 1	38	female	Suicidal - depression Aching joints - and limbs Exhaustion	Depression	yes	no	Temporary council flat	Council tenancy Living with partner	Temporary - council flats	2.5 years	Centre for people with mental health problems
Gareth	SFD 2	49	male	Arthritis Walking probs	N/A	yes	no	Lodging house	N/A	Hostel Lodging house Bed and breakfast	+ 14 years	Centre for people with mental health problems
Roz	CST 1	42	female	Asthma Anxiety	Asthma Anxiety Sleeping probs	yes	no	Direct access hostel for homeless women	Council tenancy Living with partner	Current accom.	2 months	Hostel for homeless women
Jo	CST 2	20	female	Depression Gall stones Headaches	Gall stones	yes	no	Direct access hostel for homeless women	Parental home	Sharing - friends Hostel	6 months	Hostel for homeless women

<u>Name</u>	<u>Interview code</u>	<u>Age</u>	<u>Sex</u>	<u>Current health problems</u>	<u>Health problems when last at home</u>	<u>Currently registered with a GP?</u>	<u>In receipt of sickness/invalidity benefit?</u>	<u>Current accommodation</u>	<u>Last home</u>	<u>Accommodation since becoming homeless/last 5 years</u>	<u>Length of time homeless</u>	<u>Location of interview</u>
Lizzie	CST 3	23	female	Eating probs Sleeping probs Anxiety/stress	Eating probs Sleeping probs Anxiety/stress	no	no	Direct access hostel for homeless women	Parental home	Sharing - friends Sharing - relative	11 months	Hostel for homeless women
Chris	CST 4	22	female	Depression	Depression Anxiety/stress	yes	no	Direct access hostel for homeless women	Private tenancy Living with brother	Current accom.	3 month	Hostel for homeless women
Pat	CST 5	28	female	Epilepsy Flu/Colds Back pains	Back pains	yes	yes	Direct access hostel for homeless women	Tied accommodation Living with partner	Sleeping rough Sharing - friends Sharing - relatives Hospital	6 years	Hostel for homeless women
Nicky	CST 6	27	female	Depression Learning - difficulties	Depression Learning - difficulties	yes	no	Direct access hostel for homeless women	Parental home	Sharing - friends	1 month	Hostel for homeless women
Carol	CST 7	27	female	Anxiety/stress Sleeping probs Dermato - logical probs Behavioural - probs	Suicidal - depression Sleeping probs Dermato - logical probs Behavioural - probs	yes	no	Direct access hostel for homeless women	Parental home	Current accom.	1 month	Hostel for homeless women
Fiona	CST 8	21	female	none	none	yes	no	Direct access hostel for homeless women	Private tenancy Living alone	Sharing - friend	6 months	Hostel for homeless women

N.B. Information presented in *italics* concerns respondents whose accommodation histories could not be traced back to when they were last at home and were instead traced for the previous five years.

APPENDIX 2

The Health of Homeless People: A Housing Issue.

Interview Schedule

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October 1993

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A RESEARCH PROGRAM FUNDED BY THE ECONOMIC AND SOCIAL RESEARCH
COUNCIL

What Does the Interview Involve?: Information for the Respondent.

1. I will ensure that you remain anonymous.
2. If I ask any questions you do not want to answer just say so and we will talk about something else.
3. If, for whatever reason, you want to end the interview just say so and it will end immediately.
4. The interview will be taped to save me writing everything down. After I have listened to the tape it will be destroyed.
5. During the interview I may take a few notes. All I am doing is trying to do is get things clear in my head and making sure I do not ask you the same question twice.
6. During the interview I will be turning over pages. All I am doing is reading through a list of questions to make sure that I have asked all the questions I wanted.
7. The interview should last about 45 minutes at the most.
8. Is that all okay? Do you have any questions? Are you ready to begin?

Interview Schedule - Summary Sheet.

Personal Characteristics

- age, marital status, employment status?

1. Accommodation history.

a). *Present accommodation* - conditions, happy, length of residence?

b). *Prior accommodation* - length of residence, who with, employment, conditions, happy, previous accommodation?....REPEAT...

2. Current health status.

a). *General Health, health for age* - excellent, good average, poor, very poor?

b). *Specific Problems* - NO - skip to 3.

YES - what, how long, cause, treatment, day to day effects, peoples attitudes, concern?

3. Health when last at home.

a). *Last at home* - where, what accommodation, when, with who, why left?

b). *Health at this time* - general health, specific problems?

- NO - skip to 4.

- YES - cause, treatment, day to day effects, people attitudes.

4 Impact of homelessness on health.

a). *Health since leaving last home* - worse, problems?

- NO - skip to 7.

- YES - why, environment, health care?

5. Leaving home and becoming homeless.

a). *When at last at home* - reason for leaving?

b). *Search for other accommodation* - where - L.A., H.A., hostels, friends/relatives....?

- why not L.A., H.A., hostels, friends/relatives....?

c). *What accommodation moved into* - REPEAT until in current accommodation.

6. Escaping homelessness.

a). *Do you want to move out* - where have you tried L.A., H.A., hostels, friends/relatives - experience and outcome ...?

- why haven't you tried L.A., H.A., hostels, friends/relatives....?

7. Home - wants and needs.

a). *What accommodation would you like* - why, what would it have different to now, have you tried to access....?

Personal Characteristics

Before we get going I would like to ask you just a few quick questions:

a). First of all, what is your age?

b). What is your marital status - at the moment are you;

- single, married or with a partner, separated, divorced.

c). At the moment, are you employed?

- YES - what do you do - how long have you had this job?

- NO - when did you last have a job?

d). What benefits are you receiving?

- income support, sickness/invalidity benefit, pension....?

A. Accommodation history.

To start with I'd like to talk about where you are living at the moment.

1. What accommodation are you living in at the moment?

- house, flat, bed sit, supported accommodation, sharing with a friend or relative, B and B, long stay hostel, squat, short stay hostel, sleeping rough.
- mortgaged, private rented, local authority, housing association, other.

2. What are conditions like?

- the physical environment - warmth, cleanliness, hygiene etc.?
- facilities - eating, washing and toilet facilities, sleeping arrangements?
- do you share facilities with other people?

3. Are you happy living there?

- why?
- why not?
- do you get on with the other people who live there?
- can you get peace and quiet - be on your own if you want?
- does living in this accommodation affect your day to day freedom e.g. can you do as you please, come and go as you please, stay as long as you want?
- do any rules or regulations bother you / affect you?
- is it a safe place to live - do you feel safe?

4. When did you move into your current accommodation?

- so you have lived there for how long?

5. Where did you live before you moved into your current accommodation?

- where? - what type of accommodation?

6. How long did you live there for?

7. Were you living alone OR with friends, a partner, your family, just sharing?

8. What were you doing at this time - working, at school, unemployed?

- discuss i.e. to set the context and to aid recall.

9. What were conditions like?

- the physical environment - warmth, cleanliness, hygiene etc.?
- facilities - eating washing and toilet facilities, sleeping arrangements?
- did you share facilities with other people - who?

10. Were you happy living there?

- why? / why not?
- did you get on with the other people who lived there?
- could you get peace and quite - be on your own if you wanted?
- could you do as you pleased, come and go as you wanted, stay as long as you wanted? Did the restrictions bother / affect you?
- was it a safe place to live - did you feel safe?

11. Where did you live before you lived there?

- where / what type of accommodation?

Repeat Questions 6 to 11 back until 'last home' OR until the respondent is uncertain of the details OR the recall period is more than five years - use discretion!

B. Current health status.

Okay, what I'd like to do now is to move on to talk about what you think of your present state of health. When I say health I am not just talking about problems that have been diagnosed by a doctor but also things you are aware of.

12. Would you describe your health as excellent, good, average, poor, very poor.

13. How would you describe your health compared to others of your age?

- excellent, good, average, poor, very poor.

14. So, at the moment do you think there is anything wrong with your health?

- have you any illnesses or health problems that you are aware of, for example, any signs or symptoms like - any aches or pains,
- anything that effects what you can do day to day?
- any use of drink or drugs?
- any times of feeling down, being worried or depressed?
- anything diagnosed by a doctor as a problem?

NO - SKIP TO 21

YES - what is the matter, is it getting better, worse or staying the same and in what way? - have you any other health problems?

15. Have you ever talked to a doctor or any other health worker about these problems?

YES - what did they say - did they give a diagnosis?

- did they offer any advice, help?
- did you ever receive any treatment? (once, more than once, regularly) - from the doctor, by attending a clinic, or in hospital?

NO - why not?

- are you registered with a GP? - where?

16. How long have you had these health problems - when did the problems start?

17. What caused these health problems?

- was it something you were born with - genetic?
- was it because something got you up tight and worried - stress?
- was it because of where you were living, the area, the house - environment?
- was it because of how you were living - lifestyle?
- was it down to circumstance - bad luck?

18. Do these problems affect your day to day life in any way, like restricting or limiting what you can do?

- how?
- do they affect getting around, walking, mobility?
- make you tired?
- do you worry about it, does it get you down?
- are you in pain?

19. Do you think that your health affects the way people treat you?

- how?
- does it affect how people look at you, talk to you, act toward you?
- the opportunities open to you, for example work?

20. Does your health concern you - do you worry about it?

- YES - why? - should it be better?

- NO - do you think it could be better?
- how do you think your health could be improved?
- do you think that improving your life style (housing, living environment, diet) would have any effect upon your health
- improving the quality and access to health care?

C. Health when last at home.

Okay, so we have talked about where you are living at the moment and your present state of health. What I'd like to do now is to talk about where you have lived in the past and how your health was then.

21. Thinking back through the different places that you have lived in, when would you say was the last time that you were living somewhere that you felt at home?

- why did you feel at home here - what made it home?
- what kind of accommodation was it - house, flat, bed sit, squat, hostel, shanty, etc., mortgaged, local authority, housing association etc.?
- if different to last home as secure, permanent accommodation - why?
- when were you living there - how long did you live there for?
- were you sharing the house with anyone - who?
- what were you doing at that time - working, at school, unemployed, etc.?

22. Thinking back to when you were living in your 'last home' (secure, permanent accommodation), was your health at this time excellent, good, average, poor, very poor?

23. When you were living there was there anything wrong with your health?

- did you have any illnesses or health problems that you are aware of, for example, any signs or symptoms like - any aches or pains?
- anything that effected what you could do day to day?
- any overuse or dependency on drink or drugs?
- any times of feeling down or of being depressed.
- anything diagnosed by a doctor as a problem?

NO - SKIP to 28

YES - what was the matter?

- did you have any other health problems at this time?
- did you have these problems before you left this 'accommodation'?

24. Did you receive any help or treatment from a doctor or a other health worker for these problems?

- what help/treatment did you receive?
- where did you get this help - in hospital, in a clinic, at a GP.?
- once, more than once or regularly?
- were you registered with a GP? - where?

25. What caused your health problems?

- was it something you were born with - genetic?
- was it because something get you up tight and worried - stress?
- was it because of where you were living, the area, the house - environment?
- was it because of how you were living - lifestyle?, bad luck?

26. Did these problems affect your day to day life in any way, like restrict or limit what you could do - in what way?

- did they affect getting around, walking, mobility?

- make you tired?
- did it get you down?
- were you in pain?

27. Did your health affect the way people treated you?

- in what way?
- how people looked at you, talked to you, acted toward you?
- the opportunities open to you, for example work?

D. The impact of homelessness on health.

We 've already talked about your current health and your health when you were living at 'home'. What I'd like to talk about now is the period in between and how your health has been in the time since you left your 'home'.

28. How has your health been in the time since you became homeless - has it got worse, improved or stayed the same?

- if it has changed, in what way - more severe, the development of a range of problems - what problems?

If no past or present health problems SKIP to 39.

29. You say that since becoming homeless you have experienced health problems

- what caused them?

- the continuing presence of existing problems?
- have they got better - why / why not?
- OR the emergence of new problems - why / why not?

Environment?

- the accommodation that you have lived in?
- the facilities available to you (washing and toilet facilities, sleeping arrangements, cooking facilities and availability of a healthy diet)?
- the physical environment (warmth, damp)?
- the worry and concern of living in this environment (physical threat of accidents and violence)?
- the availability of help and support?
- support networks - someone to talk to (friends and relatives)?

Availability of health care?

- have you had medical help with your health problem?

YES - who from; outreach worker, GP., doctor or nurse at a clinic or hospital?

- what help was provided; one off treatment, course of treatment - why; did your circumstances affect the treatment that you were given?
- was the help you received adequate - could it of been better - how?
- has getting medical help affected your health, improved it?

NO - why not; out of choice, unsure where/how to get help, help not available - why not, because of your circumstances?

- do you want medical help with your health problem - could you get this help in other circumstances, if your were not homeless?

E. Leaving home and becoming homeless.

Still thinking back to the time when you were living in your 'last home':

30. Why did you leave your 'last home'?

- were there problems at this time that meant you had leave, such as;
- relationship problems?
- financial problems?
- threats of or experience of actual violence?
- entry to an institution such as a hospital or prison?
- being forced to leave by the property owner?
- or was it something else?

31. You said that you had health problems before you left your home, was the property owner (friends or relatives, housing officer, private landlord, mortgage lender) aware of your health problems?

- did they ask about the reasons behind why you were having to leave?
- did they enquire as to your health/well being?
- did you tell them?
- did they act on this information?

32. Did your health problems in any way contribute to you losing your home?

- in what way?
- did they effect the reasons why you had to leave your home?
- relationships with family and friends?
- financial circumstances e.g. loss of work?
- entry into an institution e.g. hospital, prison?
- actions of the property owner?

33. When you realised that you were going to have to move out, where did you look for alternative accommodation?

- local authority, housing association, private landlord, friends, relatives, hostels, etc.

34. When you approached the local authority; the housing association; the hostel; the private landlord; your friends; your relatives; (as applicable).....see Supplement 1

35. Why didn't you approach the local authority; a housing association; a hostel; a private property owner; friends; relatives; (as applicable)?

- why not, did something put you off - a past experience?
- what did you expect to happen if you had approached them?

36. So, what accommodation did you move into?

Repeat 30 to 36 until in present accommodation.

F. Escaping homelessness.

We have just about covered everything that I wanted to talk about, I'd like to finish by coming up to date and talking about where you are living at the moment.

37. Do you want to move out of where your are living at the moment?

- why / why not?
- where do you want to move to - what accommodation?

38. Have you tried to get any other accommodation?

- what have you tried - local authority, housing association, hostels, friends and relatives, private owners etc.?
- when you approached the local authority; the housing association; the hostel; the private owner; your friends; your relatives; (as applicable)...see Supplement 1
- why didn't you approach the local authority; a housing association; a hostel; a private property owner; friends; relatives; (as applicable)?
- why not, did something put you off - a past experience?
- what did you expect to happen if you had approached them?

G. Home - wants and needs.

Finally;

39. In what accommodation would you like to live?

- why?
 - what would it provide you with that you haven't got now?
 - what do you need from accommodation?
 - would it effect your health?
 - can you get access to this accommodation?
- (Yes - are you trying to and if not why not, No - why not?)

That's all the points I want to cover, is there any points that you feel should be raised that we haven't discussed?

SUPPLEMENT

Local Authority

Outcome?

- what was your hope - was it fulfilled?
- did you get an offer of accommodation?
- do you know why / not?
- what reasons did they give?

Homeless?

- could you get help because you were homeless?
- did they recognise you as homeless?
- did they say that you were intentionally homeless?
- what reasons did they give?

Health?

- could you get help because of your health problem?
- did they assess your health problems - how?
- could you get medical priority in the waiting list - were you recognised as vulnerable because of your health problem?

Any Help?

- were the local authority of any help to you in your attempt to find

accommodation?

- what help should they of given you?

Housing Association/Hostels/Bed and breakfast/Lodging house.

Outcome?

- which housing associations/hostels did you approach - why?
- what was your hope when you approached them - what type of accommodation were you hoping for - was this hope fulfilled?
- how did you approach them - through the L.A., through another agency or individually?
- did you get an offer of accommodation?
- do you know why / not?
- what reasons did they give?

Homeless?

- did they recognise you as homeless?
- could you get help because you were homeless?

Health?

- did they offer you help because of your health problem?
- did they assess your health - how?
- did your health have any effect on their decision?
- what help should the housing associations of given you

Friends/Relatives

Outcome?

- what were you hoping they could provide - was this hope fulfilled?
- did they offer you any accommodation?
- do you know why / not?
- what reasons did they give?

Health?

- did they know about your health - did you tell them - did they ask?
- did your health effect their decision?

APPENDIX 3

Information Sheet 2 -The Health Of Homeless People: A Housing Issue.

An Edinburgh based study of peoples housing careers and health histories.

The Interview Process - What Does it Involve for the Respondent?

The aim of the research is to make practical suggestions on how housing policy can be improved so as to reduce the likelihood of people with health problems experiencing homelessness. These practical suggestions will be based on the *experiences* of people living in different circumstances and situations who have experienced problems acquiring and/or holding on to adequate housing. This information will be gained through interviewing homeless people.

Who is wanted to take part in the interviews?

- homeless people living in Edinburgh who are willing to talk about their experiences.

What will the interview involve?

- a one off, casual, taped interview that should not last more than an hour.

About what?

- their views and experiences of housing services, e.g. the council, housing associations, hostels, etc.;
- their health and experiences of health services;
- their experience of being homeless.

ALL INTERVIEWS ARE ANONYMOUS. RESPONDENTS CAN REFUSE TO ANSWER ANY QUESTIONS AND HAVE AT ALL TIMES THE RIGHT TO WITHDRAW FROM THE INTERVIEW.

All respondents will receive £5 for their time

Information Sheet 1 -The Health Of Homeless People: A Housing Issue.

An Edinburgh based study of peoples housing careers and health histories.

AIM - To make practical suggestions for improving the poor health profile of homeless people.

BACKGROUND - Homeless people are experiencing a high incidence of a range of mental and physical health problems compared to the general population.

METHOD - Information on the experiences of homeless people with health problems will be collected by interviewing people attending services for homeless people in Edinburgh. All respondents will remain anonymous and have the right to refuse to answer any questions and to withdraw from the interview at any time.

OUTPUT- Practical suggestions about how to improve housing policy and reduce the likelihood of people with health problems becoming and remaining homeless, and limit the impact of homelessness on health.

DAVID ROBINSON - Dept. of Geography, University of Edinburgh, Drummond St., Edinburgh. EH8 9XP. 031 650 2532.

A RESEARCH PROGRAM FUNDED BY THE ECONOMIC AND SOCIAL RESEARCH COUNCIL.

HELP REQUIRED

Can you spare some time for a chat?

When?: During the week *January 24 - 28.*

Where?: At the *Peoples Palace.*

What's involved? - a one off, casual, taped interview
hopefully not lasting more than
an hour;

About what?: - the places you have lived;
- what it was like to live there;
- your health.

ALL RESPONDENTS WILL RECEIVE £5 FOR THEIR TIME.

**ALL INTERVIEWS WILL ANONYMOUS. YOU CAN REFUSE TO ANSWER ANY
QUESTIONS AND WITHDRAW FROM THE INTERVIEW AT ANY TIME.**

David Robinson. Dept. of Geography, University of Edinburgh, Drummond Street, Edinburgh, EH 8 9XP. (031) 650 2532

APPENDIX 4

CATEGORIES FOR HYPERSOFT ANALYSIS

1. CURRENTACCOMMODATION h s f r b - a general category referring to all information about the respondent's current accommodation.

Sub-categories - HOSTEL

FRIENDS/RELATIVES

ROUGH - sleeping rough, squatting etc.

SUPPORTED - supported accommodation.

INSTITUTION - hospital, prison etc.

LODGINGHOUSE - bed and breakfast accommodation, lodging house.

TYPE - type of tenure, arrangement etc.

CONDITIONS - facilities - eating, washing etc. - and the physical environment - warmth, cleanliness etc. of where the respondent is currently living.

HAPPY - respondents feelings about living in their current accommodation - problems, difficulties, restrictions, benefits, advantages etc.

2. PASTACCOMMODATION 1 2 3 4 5 6 - a general category referring to all the different accommodation that a respondent lived in prior to their current accommodation and since becoming homeless. The numbers are a time measure, 1 = accommodation immediately prior to the current, 2 = accommodation before that etc.

Sub-categories - HOSTEL

FRIENDS/RELATIVES

ROUGH - sleeping rough, squatting etc.

SUPPORTED - supported accommodation.

INSTITUTION - hospital, prison etc.

LODGINGHOUSE - bed and breakfast accommodation, lodging house.

PTYPE - type of tenancy, arrangement etc.

PCONDITIONS - facilities and the physical environment of accommodation in which the respondent has lived since becoming homeless.

PHAPPY - respondents feelings about living in their past accommodation - problems, restrictions, benefits etc.

3. HOMEACCOMMODATION - a general category referring to all discourse on the respondents last home i.e. last secure accommodation - rented/mortgaged, parental home, partners home etc.

Sub-categories - HTYPE - nature and type/tenure of home accommodation.

HCONDITIONS - facilities and physical environment of the home accommodation.

HHAPPY - respondents feelings about living in their home accommodation - problems, restrictions, benefits etc.

4. HEALTH - A general category referring to all discussion of the respondent's current health.

Sub-categories - QUALITY - a grading - excellent, good, average, poor, very poor - of the respondent's feelings about their present state of health and their state of health compared to others of their age.

PROBLEMS - the respondent's current organic, social and functional health.

CAUSE - feelings as to the reasons for current health problems.

TREATMENT - any treatment that the respondent is currently receiving from a health care provider, whether they are registered with a GP, utilisation of health services etc.

CONCERN - respondent's concern about their current health and how could it be better.

HEALTH IMPROVE - how could the respondent's health be improved - lifestyle, healthcare, environment...

5. HOMES - last experience of feeling at home.

6. PHEALTH - a general category referring to all discussion of the respondent's health when at last home i.e. in secure accommodation.

Sub-categories - PQUALITY - a grading - excellent, good, average, poor, very poor - of the respondents feelings as to the state of their health when last at home.

PPROBLEMS - respondent's organic, social and functional health when last at home.

PCAUSE - feeling as to the reasons for health problems when last at home.

PTREATMENT - any treatment that the respondent received when living at home, whether they were registered with a GP, utilisation of health services...

7. CHANGE - perception of how health has changed in the time since becoming homeless - better, worse, the same - and details of the nature of the change.

Sub-categories - CARE - the importance, or otherwise, of access, availability and nature of health

care received in effecting health since becoming homeless.

ENVIRON - the importance, or otherwise, of lifestyle and environment on health since becoming homeless.

8. LEAVING - a general category referring to all discussion about leaving last home.

Sub-categories - WHY - reasons for leaving home/having to leave home, i.e. last secure accommodation.

HOMEOWNER - awareness and reaction of the home owner (landlord, mortgage lender, parent/guardian, partner..) to respondent leaving home.

9. HSEARCH 1 2 3 4 - general category referring to all attempts to access accommodation when leaving home. Numbers are a time measure, 1 = first attempt.

Sub-categories - COUNCIL

HA - Housing associations.

PR - private rented.

HOSTEL

FRIENDS/RELATIVES

LODGINGHOUSE - bed and breakfast accommodation, lodging house.

OO - owner occupation.

HOMELESS - significance or otherwise of being homeless to the application procedure when attempting to access accommodation.

HEALTH - significance or otherwise of health to the application procedure - health assessments, medical priority system.

ADVICE - importance/influence of advice to application procedure.

10. ACCOMMSEARCH - general category referring to all attempts made at various times to access both temporary or permanent accommodation.

Sub-categories - COUNCIL

HA - housing associations.

PR - private rented.

HOSTEL

FRIENDS/RELATIVES

LODGINGHOUSE - bed and breakfast, lodging house.

OO - owner occupation.

HOMELESS - significance or otherwise of being homeless to the application procedure when attempting to access accommodation.

HEALTH - significance or otherwise of health to the application procedure - health assessments, medical priority system.

ADVICE - importance of advice to application procedure.

11. IDEAL - the kind of accommodation that the respondent would like to live in, why and what it would provide them with.

12. MORE HELP - more/different help that accommodation providers could of given to the respondent when attempting to access accommodation.

13. OFFERS - reasons for applying to an accommodation provider, hopes, expectations and offers/rejections.

14. PRESENT SEARCH - general category referring to current attempts to access accommodation - agencies approached, application process and outcome.

Sub-categories - COUNCIL

HA - housing associations.

PR - private rented.

HOSTEL

FRIENDS/RELATIVES

LODGINGHOUSE - bed and breakfast accommodation, lodging house.

OO - owner occupation.

HOMELESS - significance or otherwise of being homeless to the application procedure when attempting to access accommodation.

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